MENTAL HYGIENE

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The National Association for Mental Health, Inc.

The Voluntary Promotional Agency of the

Mental Hygiene Movement

Founded by Clifford W. Beers

Objectives

The National Association for Mental Health is a voluntary organization working for the promotion of mental health; for the prevention of mental and nervous disorders; for the improved care and treatment of the mentally ill; and for the special training and supervision of the mentally deficient.

QUARTERLY MAGAZINE

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THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

1790 BROADWAY, NEW YORK (19), N. Y.

MENTAL HYGIENE aims to bring dependable information to every one whose interest or whose work brings him into contact with mental problems. Writers of authority present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public are republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology are presented and discussed in as nontechnical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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ORIGINAL CONTRIBUTIONS

MENTAL HYGIENE

SAMUEL WARREN HAMILTON
1878–1951

MENTAL HYGIENE

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THERAPY—THERAPEUTIC—THERAPIST

JOHN had passed through a comfortable and relaxing eight-hour session of sleep therapy, but it was beginning to get light outdoors and the time had arrived for his next treatment—waking-up therapy. This was accomplished without drag or push, and landed him on the brink of his third session—getting-dressed therapy. In keeping with his mood, his clothes to-day consisted of underwear, socks, shoes, pants, and shirt. But the donning of his shirt was deferred until the fourth therapy in the day's series of treatment was completed—toilet therapy.

There are many ways of going to breakfast, but since John needed socialization, a group of patients, including John, took their going-to-breakfast therapy together. Breakfast therapy was chalked up as the sixth in the total push of intensive therapy. And before the circle of the day had been completed with going-to-bed therapy, thirty-four such lifts had been given John toward eventual recovery.

What is therapy, anyway? Is it anything at all that is good for a person—food, recreation, work, music, and so on? Or does it have some more specific value, so that one can say this treatment is given to a patient to heal *this* disease, but would not be effective in treating *that* disease? Is intent the only criterion of therapy—the intent to treat a person for a certain disease? Or must the intent be backed up with reasonable evidence that this treatment may be effective? Must the person who administers the treatment be professional? Must the treatment be prescribed by a professionally skilled person? May it be administered by any one sufficiently skilled to make it effective? Having decided what constitutes therapy, can we say that something is therapeutic, even if it is not therapy?

The answers to some of these questions are not settled. They would to-day certainly be just one person's opinion. Still, to almost every one the term, therapy, implies something more distinctive than that which is merely good for a person, such as food. It implies that the person must be ailing and that the administration of a certain diet or treatment must be understood to be good for an ailing person, if not for his specific ailment. Thus limes in the diet in a case of scurvy were hardly therapy before it was discovered that they cured scurvy. The therapeutic effect of this diet was quite accidental and not intended. Now, however, there can be no doubt that a physician administering this treatment for scurvy would properly be called a therapist. On the other hand, this term would hardly apply to one whose task it is to prepare meals. There is implied in the term special skill and knowledge.

The dictionaries are no help in settling these questions and still the questions are important because the term, therapy, is used very loosely at present. Again and again healing claims are made for this or that procedure without distinction as to the specific disorder for which it is applied. Some of these procedures are good for anything, but for no specific condition. And so we have "recreational therapy" that is simply good play for anybody. To apply the term, therapy, to play does not, of course, change the effects of play, but it does imply that recreation as such is not quite as important as recreational therapy. On the other hand, play therapy is often very specifically designed and is then more than, and possibly very different from, play. The terms, educational therapy and music therapy, are used in this same loose sense, and even occupational therapy is often just a fancy name for busy work.

The use of the term, therapy, seems to lend authority, dignity, and scientific justification to some very ordinary procedures. Because it has a tone of the progressive, the easy use of the term may ultimately thwart real progress. It has a scientific connotation, an idea that the activity in question is carried on with a knowledge that is superior to that which characterizes the activities of everyday life. This pretense of a scientific foundation, therefore, removes the incentive to scientific evaluation and experimentation. If

we were to reserve the use of the word, therapy, only for procedures specifically designed for and aimed at certain ailments, or even groups of ailments, there would be more incentive to establish justifications of such procedures. This does not mean full validation, but sufficient empirical or rational bases to warrant their use.

The term, therapeutic, does not exactly parallel the term, therapy. We can think of the word, therapeutic, as reflecting an effect, quite apart from intent. Some therapy turns out not to be therapeutic. This is often the case with penicillin, which may be appropriately given in terms of the disorder, but may result in such a reaction in the patient that the effect of it is negative rather than positive. At the same time some things, as in the case of limes in the diet, were therapeutic before they became therapy.

And what about the term, therapist? This term means something more than a mere administrator of a technique. It implies deeper understanding. It carries with it assurance to the patient that the person administering the therapy knows what he is doing. The term should, therefore, be used with caution and only when that person has certain skills and knowledge that permit him to apply measures discriminately and with an awareness of the cautions to be exercised.

In the light of these principles, it is quite clear that there is such a thing as play therapy, but also that much of what is termed recreational therapy is just good recreation that is not specifically designed to treat a certain ailment or groups of ailments. Occupational therapy is often nothing more than mere occupation which is not specifically therapeutic and is often administered by a person who has no more than the manual skills needed to carry on the work. Such a person is not a therapist. Music therapy is for the most part, if not entirely, a misnomer. It is simply music, which is good for most people. Educational therapy, in so far as it is distinct from psychotherapy, is in the same category.

The more we recognize these inconsistencies in our use of the words, therapy, therapeutic, and therapist, the clearer will be the gaps in our present knowledge and the stronger will be the incentive to fill in those gaps by adequate research.

GEORGE S. STEVENSON

COMMUNITY PSYCHIATRY AND ITS ORGANIZATIONAL PROBLEMS

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IN many individual communities, community psychiatry has now come to the point where an integration of all facilities that deal with the treatment of mental illness and with the preservation of mental health has become possible. Moreover, experiences in communities all over the country show that such a unifying reorganization is urgently needed.

I am not referring here to a program of action—how to get the community forces mobilized; how to get a mental-hygiene society, and then a mental-hygiene clinic or child-guidance clinic, going; how to set up a training program for psychiatric personnel; how to reorganize state hospitals and state training schools into true treatment institutions; and so on. Forceful movements are under way to inaugurate, and—we hope—to accomplish, all that in the not too distant future.

As a matter of fact, the psychiatrists in many a community may well feel like the sorcerer's apprentice, as far as conjuring up community action is concerned. Strong forces have been set into action and demand to be used. Many communities, small and large, have become very much aware of their deficiencies in the area of curative and preventive psychiatry. They are, financially and otherwise, ready to act. They desire to improve and to expand their existing psychiatric facilities, and they desire to develop more adequate new ones. The psychiatrists in the community are expected to be the leaders in this movement. At this point it suddenly becomes apparent that they are not prepared to take that leadership. They find themselves unable to deliver the goods that they have been trying to sell for the last twenty years.

We are told that scarcity of psychiatric personnel makes large-scale development of community mental-hygiene facilities impossible at the moment. Psychiatric personnel in sufficient quantity will first have to be trained. Whoever has tried

recently to secure the services of an experienced psychiatrist, a clinical psychologist, or a psychiatric social worker for a community clinic will agree that this is a very difficult task. Yet I do not think that "scarcity of psychiatric personnel" should be used too much as a scapegoat. We may overlook other urgent problems if we rely too exclusively on that excuse. It may backfire when, thanks to our new training programs, psychiatric personnel is available and yet many "treatable" neurotics still go untreated and uncured.

Experience has shown time and again that a mere increase in staff, a mere extension and multiplication of treatment facilities, does not solve the problems of unmet needs. The new facilities, if merely a copy of those that we now have, will suffer as ours do—from unrealistic waiting lists; from "having spread themselves too thin"; from having "withdrawn into an ivory tower"; and all the other ills that have beset community psychiatry for the last twenty years. One shudders, on the other hand, when one thinks of all the psychiatric personnel that eventually would be necessary to treat all the treatable neurotics in a community.

One of the reasons for this inexhaustibility of our reservoir of neurotics lies, of course, in the fact that our therapeutic methods are far from being as infallible and effective as many of us seem to assume. Another reason for it is to be found in the fact that mental illness as a public-health problem can be fought effectively only by preventive methods, and these are not yet sufficiently developed.

These two all-important problems—further improvement of our therapeutic methods and development of efficient preventive methods—can be attacked only step by step. No quick immediate solutions are to be expected in those two areas. However, another problem of great urgency is open to immediate attempts at solution. This problem is not as important scientifically as the two mentioned above, as it is mainly organizational and methodological in nature; nevertheless, it is important from a practical point of view. How can we fit together into an efficient whole all the many small and large pieces of psychotherapeutic methods that now operate in isolation in most communities, to the stupendous waste of professional time and efficiency

Fortunately there are abundant signs of a development very

different from the mere extension and multiplication of existing facilities. New concepts have recently been created. We moved gradually from "treatment of the mentally ill" over "early treatment of neurosis and psychosis" to "prevention of mental illness." Recently a new step has been taken and a new goal has been set. I want to mention here only two representative formulations of that new trend: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (from the Constitution of the World Health Organization) and "to help the children of the next generation grow into mature adults" (from a statement made at the International Congress for Pediatrics, Zurich, 1950). The concepts, "prevention and treatment of mental illness," are still contained in these formulations. They are much broader, however, and accomplish a most significant shift in emphasis, from the prevention and treatment of disease toward the promotion of well-being.

These steps—from treating the mentally deranged, or even from merely taking care of them, to a prophetic vision of helping a future generation grow into full and early emotional maturity—these steps have been taken by psychiatry not merely in theory. Community psychiatry as a practical science and art has moved on steadily in that same direction. Numerous new methods are being developed in response to the slowly developing new concepts. Some of them originated as improvisations. Others were planned as new independent ventures from the beginning. They are in every phase of development, some of them still in the earliest stages of experimentation, others already well established and well standardized methodologically.

The list that follows will give an idea of the variety and importance of such experiments in the areas of curative psychiatry and preventive mental hygiene; it does not pretend to be complete:

Psychiatric services in prenatal clinics;
Psychiatric services to adoption agencies;
Child health centers;
Psychiatric and psychological services in children's hospitals;
Psychiatric and psychological services in schools;
Counseling services and psychiatric services to students in high schools, colleges, and universities;
Clinics for reading difficulties and other specific learning defects;

Psychiatric services for the handicapped;
Vocational-guidance clinics;
Psychiatric consultation services in children's institutions;
Psychiatric services in homes for emotionally disturbed children (receiving homes and treatment homes);
Psychiatric services in state training schools;
Psychiatric services in juvenile courts;
Psychiatric consultation services to family agencies and child-welfare agencies;
Marriage counseling;
Psychiatric consultation services in homes for unwed mothers;
Psychiatric services in general hospitals and so-called psychosomatic services;
Psychiatric consultation services to courts, and to parole and probation departments;
Psychiatric services in correctional institutions;
Experiments in group therapy with adults, adolescents, and children.

The oldtimers in the field of community psychiatry should be added:

Mental-hygiene societies;
Mental-hygiene clinics;
Child-guidance clinics and child psychiatric clinics;
Psychological clinics with various functions and assignments;
Psychiatric outpatient clinics connected with psychopathic hospitals, general hospitals, and state hospitals.

This is a formidable array. Even granting that some of the enumerated services are not as important and as valid as others, and that some are mere variations of others—even granting that, we need not be ashamed of the quantity or quality of new developments. A great deal has been accomplished during the last years. Also, the trend from curative toward preventive psychiatry can clearly be discerned in this development.

The reader of this paper may well have experienced some sense of confusion and bewilderment when confronted with the checkered and unorganized multitude of the above enumeration. It mirrors our real situation in community psychiatry. One wishes that some order, some organization, could be brought into that healthy, yet a little wild, growth of old and new creations. The client certainly is bound to demand it when he helplessly tries to find the right place to get the service suitable to his problems, or when he finds himself caught in the maze of our intake and reference formalities. The planning bodies in the community are bound to ask it, the councils of social agencies, the planning and evaluating com-

mittees, and the boards of directors who are called upon to decide how much valuable service is behind the naturally a little propagandistic self-evaluations of the many clinics, counseling services, and other new creations of recent times that clamor for support.

In this paper I want to consider the question whether or not all these new enterprises should be unified in an over-all organization, and if so, how this can be accomplished.

The question has two sides, of course. There are very good arguments in favor of such a unification, and there are very good reasons why most of the new and old facilities have angrily and anxiously defended their particularistic autonomy. A discussion of the two sides of the argument may be useful.

The various services in the above list, and especially the key services, differ from one another not merely in method and functions. Each of them offers (with considerable overlapping, of course) a special form of therapy. The sum total of all these therapies constitutes the therapeutic arsenal of community psychiatry. As matters stand to-day, we have a separate facility or agency for almost every therapeutic method in community psychiatry.

The following comparison is purposely exaggerated in order to be descriptive: Imagine an independent agency for each therapeutic method used in the treatment of diseases of the heart. Then there would be, for instance, a separate outpatient clinic whose main function would be the administration of digitalis. A patient afflicted with a heart ailment who consulted that clinic would be examined there carefully with all the equipment and knowledge of modern medical science. Then, should the use of digitalis not be indicated, he would be informed of the result: "Sorry, you do not need digitalis. We think that treatment with quinidine will help you. We, therefore, advise you to go to the quinidine clinic. We shall be glad to inform them of our findings if you wish it. We cannot be sure, of course, that they will accept them. You will be most carefully reëxamined there with all the equipment and knowledge of modern science. Then the doctors of the quinindine clinic will make their decision."

One could not blame that patient should he feel that he has not been helped and that precious time, besides his money, has been wasted. The board of directors of the digitalis clinic

will feel, too, that something is wrong here, and that all those little clinics for the treatment of heart disease should somehow get together and organize themselves more efficiently. Nor could we blame the staff members of the digitalis clinic for being preoccupied mainly with their own exclusive therapeutic method. It would be only human if they were primarily interested in finding patients who need digitalis and if they even became a little frustrated and resentful, should too many of the referred cases turn out not to be in need of it (only a relatively small percentage of all patients with heart ailments do need it). Eventually they might even try to devise a system whereby the non-digitalis cases could be excluded in intake, so that the staff could devote as much time as possible to the "function" of their clinic, the development and administration of an efficient digitalis therapy.

Our situation in community psychiatry is in many respects not too different from that of our imaginary digitalis clinic. Take, for instance, the point of view of a child-guidance clinic (the point of view most familiar to the author of this paper). A child-guidance clinic is, by definition and in practice, primarily equipped to treat relationship difficulties between a child and his parents. It can, of course, deal with a number of other therapeutic tasks in addition. Its radius of action, however, is relatively narrow. It cannot be therapeutically effective if a parent is found to be so seriously afflicted that he needs intensive psychiatric treatment of long duration; if the specific character of the disturbance calls for institutional treatment of the child; if placement in a foster home is indicated; if the symptomatic behavior of the child is a direct, unneurotic reaction to an unfavorable environmental situation, inaccessible to change by psychotherapy; if the situation of a child calls for protective service; in many cases of specific learning difficulties; whenever some form of group therapy is indicated.

I am afraid that this enumeration is very incomplete. Intensive psychiatric treatment of a parent; the various forms of case-work treatment; foster-home placement; institutional treatment of a seriously disturbed child; group therapy; remedial teaching—these are, after all, merely different treatment methods. They are indicated in very many of the cases referred to a child-guidance clinic. The decision as to which

treatment (or combination of treatments) is indicated usually can be made only after a careful diagnostic evaluation by the staff of the clinic. The parent, the teacher, the pediatrician, the social worker, the judge, or whoever refers the child, cannot and should not make it. Frankly, I do not think that the intake worker of the clinic should be burdened with that responsibility. Yet the teacher, the pediatrician, and so on, have been informed (often with propagandistic fanfare) that the child-guidance clinic is equipped to give treatment to emotionally disturbed children. No mention of all those above enumerated restrictions was made.

These people then will feel most frustrated when they learn, in the course of referring cases to the clinic, that roughly three out of four of them are "untreatable" from the point of view of the clinic. To add insult to injury, the referring person frequently is blamed by the staff of the clinic for not selecting only such cases as fit the therapeutic methods of the clinic.

This situation is by no means confined to the child-guidance clinic. Every type of psychiatric facility is built around its own specific treatment methods and, because of the specificity of its organization and methodology, is not equipped to use others. Children with the same symptomatic behavior can be treated to-day by a multitude of psychiatric facilities, each of them having a different function, a different method of operation and treatment. It may be a private psychiatrist, a psychoanalytic institute, a child-guidance clinic, a children's aid society, a family agency, a children's institution, a psychiatric outpatient department.

The evaluating worker in the agency to which a child is referred, unless very, very objective, cannot help trying to fit the case to the kind of method and therapy his agency has to offer. This is his primary goal in every case. Only when defeated in it, will he, secondarily, begin to consider what other help may be available somewhere else for this patient. He will do this with a sense of frustration, however, and he even may feel a little bit of resentment against such a patient. A good many of our "untreatable" and "uncoöperative" cases belong in that category. "Untreatable" frequently means "untreatable with my pet therapy."

The psychoanalysts have been the worst offenders in that

respect, but by no means the only ones. They have tried to make the equation: psychoanalytic treatment equals psychiatric treatment. Then, on that premise, they could draw the conclusion: Therefore, what is not treatable by psychoanalytic method is wholly untreatable as far as psychiatry is concerned. Only recently has slow change in this attitude begun to take place.

This agency particularism has caused another wasteful and obstructive difficulty in those many cases in which several treatment methods in the possession of different facilities have to be combined. In many cases, this is necessary. For instance, it frequently happens that a child simultaneously needs psychiatric treatment and placement in a foster home; or that the parents of a child living in an institution need case-work treatment; or that a child needs a child psychiatrist and the parent an analyst; or that a child living in an institution needs psychiatric treatment; or that a child whose parent is in psychoanalytic treatment should be removed from home temporarily; or that a child needs group-work treatment, psychiatric treatment, and supervision by a probation officer, all at the same time. Thus it happens frequently that three or four agencies and treatment centers are involved and try to "coöperate" in the same case. It rarely works. The original willingness to collaborate is usually great and sincere. These experiments, nevertheless, have caused more frustration and interagency friction that any other situation.

The various facilities sense, of course, that they need the other treatment methods besides their own, if only as a secondary aid to their main "function." Disappointed as they have become with all those futile efforts at coöperative therapeutic action, they often try to develop those secondary treatment methods under their own control and régime. Children's institutions create their own foster-home program, their own psychiatric and case-work services; family services start their own psychiatric and child psychiatric services, and encourage their workers to do play therapy; child-guidance clinics try to attach to themselves a receiving or treatment home, to develop group therapy, to develop services for remedial teaching.

These secondary services often are of makeshift character,

poorly staffed, set up without the benefit of already existing experiences in the field in question. There just is not enough money or personnel available to equip every facility in town that is interested in problems of preventive mental hygiene (which means about every welfare agency) with an independent, complete, and effective psychiatric treatment program. Yet the trend recently has been in that direction. It is bound ultimately to lead to an increase in the isolationism of the individual facilities, to an extremely wasteful duplication of services, to the mushrooming creation of poor services and to cutthroat competition for the money and the "functions" available in the community.

The reader of this paper will not doubt, after this, that the author favors some kind of unification or integration into a functional whole of all these new and old facilities that serve the purpose of promoting mental health in the community. However, before deciding that this should be done, and especially before deciding how it should be done, let us look at the other side of the picture. The various facilities of community psychiatry have, in general, been against such plans of unification under a common leadership and administration. They often have fought such attempts, with great tenacity and with a display of considerable anxiety and resentment. There must be more compelling motives for such marked defensiveness than those that meet the eye—tradition and vested interests. These other motives will have to be considered if the planned unification is to be successful.

It is not difficult to find the most important motive for resistance to such unification. The staffs of all these old and new facilities defend the integrity and continuity of the idea and of the methods that they have developed or are developing. They know from experience that it means the end of what they have created if they come under the domination of an agency that has concepts of therapy different from their own.

The first experimental organizations serving a new function or treatment method usually are not set up according to a preconceived plan. Most of them develop casually, here and there, as somebody or some group is especially interested, or as money is available for the purpose, or as an especially crying need has to be met. The persons who embark on the

new venture usually start by using the technique and the philosophy of their mother organization—the technique of private psychiatric practice, or of child guidance, of state-hospital psychiatry, of case-work treatment, of group-work technique.

That will not do, however. The new problem, or the new function, calls for an original solution. A psychiatric service on the ward of a children's hospital demands an organization and a technique different from that of a child-guidance clinic. I dare say it even demands a different concept of treatment. The same holds true of a child psychiatric service in a treatment home for emotionally disturbed children. It would mean creating a foreign colony in that home if one tried simply to introduce there the child-guidance team and child-guidance technique, or the technique found useful in a pediatric hospital. Such simple transfers often have been attempted. They have always failed if carried out without the necessary flexibility.

Our experiences with the "psychiatric team" can serve to illustrate the point. The "psychiatric team" certainly is one of the most important methodological creations of community psychiatry. Present-day community psychiatry could not exist without it. The traditional team consists of the psychiatrist, the clinical psychologist, and the psychiatric social worker. Such a threesome has proved admirably fitted to serve the purposes of mental-hygiene clinics and child-guidance clinics. But a team of the same composition cannot serve satisfactorily in other psychiatric organizations. It acts as an irritating foreign body if established in a family agency, in a hospital, in a children's institution, in a child health center.

It can easily be seen, on the other hand, that a team consisting of a public-health nurse, a pediatrician, and a clinical psychologist, with a psychiatrist as consultant, will serve well the purposes of a child health center. A team in a children's institution, in order to be efficient, certainly will have to include the house parents or their supervisors. A psychiatric team on a pediatric ward could not do without the nurse and the pediatrician as team partners.

It is understood, of course, that such teams, in order to be "psychiatric teams," and as far as psychiatry is concerned,

must be under the leadership of at least one of the original three professions—clinical psychology, psychiatric social work, or psychiatry—and must be under psychiatric supervision. However, I do not think that we can go on insisting that all psychiatric teams shall consist exclusively of the three original professions. They do not, anyway. Teams of different composition already exist, even though their right to exist has not been officially sanctioned. Their members originally came together, not by plan and foresight, but by chance and necessity. The members of such a casually created team may have considered it a lucky coincidence that their personalities fitted together so admirably. However, it was not merely their personalities that were well suited to one another; they supplemented one another in professional knowledge and experience and thus could form a new functional whole, suited for the new task. That was the main reason why the project worked out so astonishingly well.

It was, on the other hand, not merely the presumable neuroticism or ill will of some of the members of the orthodox team that made efficient work in the new assignment impossible. Rather, their specific methods were not needed. When, in rigid pursuance of their duty, they nevertheless insisted upon applying these methods unchanged, they became an obstacle and a disturbing element in the operation of the team and of the new facility that they were to serve. They were out of place and, therefore, were bound to fail. Nothing is more apt to bring out all of an individual's neurotic potentialities than to be placed in a position in which he cannot possibly succeed professionally, and thus experiences a continuous succession of seemingly inexplicable frustrations and failures.

To create a new team, fit to serve an altogether new task, then to bring it into good operational shape, to develop and standardize new methods, to define what is done and how it is done—all these are not only creative, but also revolutionary steps. Often they have to be taken in open rebellion against healthy professional conservatism or against less healthy vested interests and narrow-minded thoughtlessness. Yet the development has to be slow in spite of being revolutionary. One has to have the privilege of experimenting, of learning from mistakes, and of making new starts. Only the guiding

idea must remain unchanged: a definition of the services to be rendered; and then, in broad outlines, a program of the methods and technique to be employed.

All that cannot be done as an aside, by a group whose main preoccupation lies in some other area. Also, it cannot be done under the domination of such a group, unless the areas of dependence and the areas of autonomy are very clearly defined, not only on paper, but above all in the minds of all the participants. Administrative dependence is possible—and in many instances desirable. The dominant group then should define what service it expects. Later on, it is entitled to object in case of gross deviations from that goal. The new psychiatric group should be flexible and should be willing to compromise when it comes to fitting its services into a wider program. It should have the fullest autonomy in questions concerning the methods by which these goals are to be reached.

The hierarchic systems that have established themselves within the group of psychiatric professions are another obstacle to the integration of the various psychiatric facilities. There are several well-set caste systems, several hierarchic orders. One of them runs: psychoanalyst—psychiatrist—psychiatric social worker; another: psychiatrist—psychologist; a third: psychiatrist—mental-health nurse. These systems already are having their typical harmful consequences, so far as concerns group relationships within the caste systems. They often have been a serious obstacle when it came to questions of fusion or unification of two or more services.

The various mental-hygiene facilities customarily are under the preponderant leadership of one profession: the mental-hygiene clinics and child-guidance clinics are directed by psychiatrists; child health centers by pediatricians and nurses; family and children's agencies by case-workers; children's institutions by group workers and educators. The hierarchically higher placed groups usually favor plans of unification of their facility with that of a more lowly placed group. The latter, in turn, usually fights such unification with anxious determination.

For instance, it happens occasionally that clinics for emotionally disturbed children are developed and staffed mainly by clinical psychology without psychiatric help beyond occasional or regular consultation. In such cases, they develop

and function differently from the customary child-guidance clinic. They are differently organized, use other methods, and set themselves different tasks. There need be little overlapping between such a clinic and a child-guidance clinic, and both can give creditable and necessary service within the same community.

In our order of values, however, the psychiatric child-guidance clinic ranges above the neighboring psychological clinic. A psychologist in a child-guidance clinic is merely one of the members of the team, unquestioningly accepting the psychiatrist as the professional leader. A psychiatrist joining the staff of a psychological clinic will very often arrive there with the idea of reorganizing the clinic according to the methods of his profession. An exodus of the old psychological staff within a year or two is the next, unavoidable step, and the clinic quickly changes into a child-guidance clinic. Whatever one's own opinion, one certainly cannot blame such a psychological group if it approaches with the utmost caution the idea of inviting a psychiatrist to join their staff, or of being unified with a neighboring psychiatrically oriented clinic. After all, who likes to be swallowed by a lion?

More in general, a weaker service often has good reasons for dreading and fighting fusion with a stronger one. It makes no difference what is the cause for the difference in strength. One of the services may be larger in size, or financially stronger, or have more prestige or more backing in the community, or it merely may have an especially aggressive and ruthless executive. The stronger service will always tend to consider such a fusion as an assimilation of the weaker service rather than as a joining of forces on an equal footing, and it will tend to permit the continuation of the functions of the weaker group only in so far as they fit into its own methodological framework. The newly created facility eventually takes on the same character and organization as the stronger of the two services had before the fusion. It has become somewhat enriched by the functions of the defunct weaker one. Very important functions previously served by the latter have become unmet needs in the process of this kind of fusion.

The following three recommendations emerge from what has been said so far:

1. It seems desirable that the individual services of community psychiatry should fit into the framework of a higher organization whose task it should be to weld together all those small and large individual services into new functional units of higher order.

2. However, the individual services of community psychiatry need autonomy as far as concerns their inner organization and their methods, their right to develop creatively, and to some degree also their right to define their own functions.

3. It will, in most instances, be preferable to create an entirely new, central organization that not only integrates, but also protects the various services, strong and weak. The other alternative—to let an already existing powerful and well-established service absorb the others—seems disadvantageous and difficult to carry through.

I am using that term, "functional unit," advisedly. For such a project of unification never could succeed if the new over-all organization were nothing but the sum total of the already existing services, loosely held together by a common administration, by free exchangeability of psychiatric personnel, and by a common training program. The success or failure of the unification will be decided around the question whether it can combine the many functions of all these services into something that is different from the sum total of the individual functions, and incomparably more efficient.

This demand for an incomparably greater efficiency is to be stressed. Otherwise, we might as well go on in our old particularistic ways. This question of greater efficiency finally brings us back to our original starting point: the problem of unmet psychiatric needs, and the fact that they cannot be met by the mere addition of new services or the mere expansion of the old ones. We may now reformulate our question: How can such a program of integration and unification do away with the inveterate ills of community psychiatry—the shortage of psychiatric personnel, of "unmet needs," of the "ivory tower," of "spreading ourselves too thin," of "waiting lists," and so on?

A detailed plan or blue print on paper, drawn up without knowledge of the particular community and its already existing psychiatric services, of its special problems and its special needs, obviously is bound to be little more than a daydream.

The hard facts of life would not be taken into account (and whoever undertakes that task in reality will have to face very hard facts). Nevertheless, some daydreaming is necessary in such a matter, if only as a preliminary step. It can serve to lay down basic principles and to analyze difficulties.

The writer of this paper is going to do some such daydreaming here, and he takes a liberty right at the very start of his daydream. He asumes that the new psychiatric super-organization will consist of several subgroups, each of them having a certain organizational autonomy while closely collaborating with the others and having closely interlacing functions with them.

He further assumes that one of those subgroups will comprise all child psychiatric services. This arbitrary, yet perhaps justified, assumption makes it possible for him to restrict his daydream to the problem of how to weld together that one subgroup of curative child psychiatry. In this area he has had most of his experience and, therefore, can speak with some authority. The solution of even this limited problem offers considerable theoretical difficulties (not to mention those that will arise should it come to translating the daydream into reality).

II

The existing individual services in child psychiatry have been about as particularistic as all the other services in community psychiatry. The good will to work with others was not lacking. On the contrary, our endeavors to find effective forms of collaboration among ourselves have been persistent and sincere. They have been happy and successful only in very sporadic instances. Occasionally it has happened that, for instance, a child-guidance clinic and a children's aid society, or a child psychiatric outpatient service and a children's institution, could enter a close and intimate working relationship while each maintained its full administrative autonomy. Some of these coalitions have been successful and lasting.

At first glance one might be inclined to see the child-guidance clinic as the center around which the child psychiatric services of a community should be organized. The arguments in favor

of such a form of organization are obvious. Child guidance has laid the theoretical and practical foundations for child psychiatry in this country. This has gone so far that child psychiatry and child guidance are almost identical in the minds of many people. The team idea was created in child guidance. This was, after all, already a very solid first step in the direction of integrating the disparate forces in the new field into a new whole that takes advantage of differences instead of stressing disagreement.

The first, easiest step in our daydream, then, would be to create a sufficiently large agency of the character of a child-guidance clinic, with the "psychiatric team" as the smallest functional unit of personnel. The clinic would be the training center for child psychiatry in the area, and it could gradually, as it develops its personnel and gains the confidence of other facilities, take responsibility for providing and supervising their child psychiatric staffs. We know that such an arrangement can work, provided the central psychiatric agency carefully restricts its influence on the other agencies to purely psychiatric matters—to supervising the psychiatric aspects of its work only, to maintaining proper psychiatric standards, to seeing to it that the agency gets really that form and type of psychiatric service that it needs and also that it makes proper use of the psychiatric staff placed at its disposal.

Collaboration between the various facilities may considerably improve under such a centralized régime. I doubt whether it would bring about a basic turn for the better so far as concerns those previously mentioned problems—unmet needs, waiting lists, and so on. Frankly, in spite of what I have just said about the importance of child guidance, I do not believe that child-guidance clinics, in their present organizational form, are equipped to take on the function of being the focal agency around which the other functions of child psychiatry could be grouped advantageously. Besides—let us face it—we have already sinned against Number 3 of our three basic rules. We have placed all other child psychiatric services under the rule of exactly the very strongest and most dominating one—the child-guidance clinic.

I should like to go a step farther and suggest that many of our present difficulties in community child psychiatry stem from the fact that child-guidance clinics have acted on the

tacit assumption that they are that focal agency. Then, when the community readily agreed and accordingly demanded that the child-guidance clinic be an all-purpose clinic so far as child psychiatry is concerned, the child-guidance people felt imposed upon and demanded the right to be selective so far as their functions are concerned. They did not mind being considered the exclusive representative of child psychiatry, yet they became indignant when asked to do work other than that in their restricted area—*i.e.*, relationship therapy with children and their parents. This is the real meaning of our constant anxious wavering between the Scylla of becoming a "diagnostic clinic" (the expression "all-purpose clinic" would be less misleading) and the Charybdis of finding ourselves isolated in the ivory tower of unadulterated child-guidance work.

The treatment of relationship difficulties between parent and child is the one specific function to which child guidance is tuned and for which it is equipped. This is only one function within the much wider field of child psychiatry. I want to stress emphatically that the function is sufficiently basic and important to warrant the establishment of such an elaborate, sensitive, and expensive apparatus as a child-guidance clinic. Also, the demand not to waste or endanger that apparatus by burdening it with other functions, is justified. However, the very specificity of its organization has extremely restricted its flexibility and its ability to adapt itself to other functions. Sometimes it also has restricted the acceptance by its staff of other points of view and of other problems than that of the disturbed relationship between parent and child.

Communities need an all-purpose clinic, a clinic that is as little selective and as little specialized within the field of child psychiatry as the family doctor is within the field of medicine. Like the family doctor, it ought to be equipped and organized to give all service that can be given quickly and to channel the other cases to the proper specialized agencies. I am convinced that such a clinic, functioning both as a quick-treatment service and as a screening service for the other, more specialized child psychiatric services (of which the child-guidance clinic is one) could considerably relieve our present difficulties. It could take over many of the functions that the specialized child psychiatric services always have found dis-

ruptive to their organization and, therefore, have tried to relegate to the area of "unmet needs." If well-functioning, it could also take care of an incomparably larger case load than the specialized services that are—and should be—geared to giving intensive service to relatively few selected cases.

The staff of such a central, all-purpose clinic will, of course, have to be multi-professional, as most of our services in community psychiatry are. The professional representation will have to be broader and more inclusive than it is on the staff of a child-guidance clinic. In addition—and in sharp contradistinction to the customary child-guidance organization—such a service will have to be multi-functional, carrying all the diagnostic and therapeutic functions that in their sum total constitute curative child psychiatry of to-day. I grant that this is a big order. One should not forget, however, that we demand such comprehensive functioning only to the same extent to which the general practitioner accepts responsibility for the total health of his patients.

This raises the question how to organize such a focal clinic, which is to comprise all the necessary diagnostic and therapeutic tools, and yet is not to compete with the other child psychiatric facilities, but rather to serve them and to facilitate their work.

The writer of this paper is not merely daydreaming in the following description of such an all-purpose clinic. The ideas developed here came to him on two recent trips to Europe, where he was asked to be consultant in the establishment of a new child-guidance clinic in Vienna. At the same time he revisited there the old child psychiatric organization[1] of which he had been a staff member many years before. This Hp., although it has gone and is still going through many crises, miraculously has preserved exactly the same organization as that developed by its staff in the twenties and early thirties. It is an all-purpose child psychiatric clinic.

The new Vienna child-guidance clinic is not in any sense planned as a competitor to the Hp. On the contrary, the Hp. is one of its sponsors, thus acknowledging the difference in function between the two services. I think it was tacitly assumed that they would exist side by side without interfer-

[1] *Heilpaedagogische Abteilung der Universitaets-Kinderklinik.* The abbreviation "Hp.," customary in Vienna, will be used also in this paper.

ing with each other's work, but also without much working together. This is, of course, impossible, and the consultant found himself compelled to think out how these two so different services, whose fabric and mode of performing he knows intimately well, could fit together. Eventually he had to realize that in practice he had no say and no influence in that matter. However, it was a learning experience for him and thus he had his profit.

He discovered that these two services, the old Hp. and the orthodox child-guidance clinic, could easily and admirably supplement each other. The Hp. is an all-purpose clinic equipped to give the extensive service that can satisfy the diverse and manifold demands of the community. The child-guidance clinic can give the necessary intensive service in those less numerous cases in which a disturbance of the parent-child relationship is the main therapeutic issue. The two types of service together could satisfy the child psychiatric needs of the community incomparably better than could two ivory-tower child-guidance clinics or two all-purpose clinics like the Hp.

We do not intend here to describe the Hp. as it is. The local coloring, the cultural and sociological differences, the differences between American and Continental psychiatry, would serve to obscure the issues with which we are concerned here. I want to describe its basic functions, though, and the methods that it has developed in response to the onslaught of the many community demands.

Two main closely interrelated functions have to be provided for in the organization of such an all-purpose clinic: diagnosis and treatment. We will start with a discussion of the out-patient department of the Hp. as a diagnostic apparatus, as a child psychiatric screening and intake center. However, as diagnosis and therapy can be separated only in theory, this will lead us later on directly into a description of the Hp. as a center in which child psychiatric treatment is either carried on or initiated.

The main diagnostic clues for the understanding of the psychiatric problems of a child can come from (1) a private talk and private interviews with the child; (2) a private talk and private interviews with the parents; (3) an observation of the child's behavior in situations that typically reproduce

everyday life situations; (4) an evaluation of the child's intellectual potentialities and achievements; (5) specific personality tests; (6) a physical and neurological examination; (7) additional information about the child and his situation in life from physicians, hospitals, schools, social agencies, and so on.

These seven items are a synopsis of our diagnostic arsenal in child psychiatry. All of them have to be available in our all-purpose clinic. However, not all of them need to be used in every case, nor should they always be used rigidly in the same way. The diagnostic evaluation of a child psychiatric problem is not a rigidly predetermined procedure. One has to be flexible in it as one has to be in any other diagnostic procedure, according to the special problems of the case, according to the knowledge one already has of it, and according to the various hypotheses one forms and discards in the course of the diagnostic procedure. Let us now see how the Hp. has solved that organizational problem of making all those diverse diagnostic tools available for quick use.

The Hp. holds its outpatient clinic twice a week. At times as many as thirty or even more clients, children with their parents, visit it in one morning. Admission is closed at 8:30 A.M. There is no other restriction of intake. I know that this sounds shocking. One has to consider the tradition behind it in order to understand it. The Hp. grew up as part of a children's hospital in which the code of ethics of the physicians and nurses demands that no one who is ill and in need of help be turned away. This is the philosophy of an all-purpose clinic or of the general practitioner. Child-guidance clinics, on the other hand, must be restrictive. They have learned through the bitter experience of many years that they are not helping anybody if they try to help everybody. This is the philosophy of the specialist. No reconciliation in one service, no coalescing of the two points of view, is possible.

This period of waiting, during which a motley crowd of anxious, upset, excited, sometimes very abnormal children and adults are held in suspense all in one room, had originally been a terrible difficulty and weakness of the organization. The staff realized that these people should not be left to themselves. At the same time the staff members were confronted with the problem how to develop a comprehensive, quick, reliable diagnostic system. Under such double pressure, they

learned to use that waiting period for diagnostic purposes, at the same time making it meaningful and therapeutic to the clients. In its final form, which was developed only slowly and after many experimentations, it was an excellent piece of group work and group therapy.

I want to make a point here. As child guidance has become increasingly focused on the problems of child-parent relationships in its therapy, it also has concentrated on that area in its diagnostic and evaluative procedures. The staff members of an orthodox child-guidance clinic hardly ever see a child in another situation than with his parents or with his therapist (who is yet another parent figure). Nothing else is considered very important, in consistency with the general child-guidance philosophy. This is regrettable. It puts blinders on the child-guidance people, blocks their approach to important psychopathological material that is easily accessible otherwise, and gives them an over-simplified picture of child life and child development, overstressing one—though probably the most important—aspect at the cost of all others.

We assume that we can in child guidance deduct everything from a child's behavior in our presence, from the content of his thoughts and feelings while in a private interview or test situation, and from the attitude and actions of his parents toward him. I still remember how time and again at the Hp. such speculations of ours about a child were shattered and surprisingly enriched by some absolutely unforeseeable reaction of the child, observed in a situation other than the one in which we were investigating or reproducing child-parent relationships.

"An observation of the child's behavior in situations that reproduce typical everyday life situations." This was one of the items in our enumeration of available diagnostic tools in child psychiatry. It hardly ever is used in child guidance. The staff members of the Hp. see it as one of their most important and most useful diagnostic methods. Very deliberately they create as wide a variety as possible of situations that "reproduce typical everyday situations," in order to observe without any prejudice what the children will do with them and in them. The resident observation and treatment center that is part of the Hp. offers a singular opportunity for such procedure. However, the waiting period in the out-

patient department is also successfully used for the same purpose. The children, instead of merely milling around or clinging to their parents, are organized into little groups. One starts a variety of group activities with them, entertains them, singles out and gives special attention to those who need it. A host of "typical everyday situations" thus can be created in a short time, provided, of course, that the procedure has been well thought out as a method, and that it is handled by well-equipped and well-trained workers.

Two main groups usually are formed—a smaller one of preschool children and school beginners and a larger one comprising the older age groups. There are always a few children who do not fit into any group and who have to be dealt with singly or in very small separate groups. Group activities then are started. The group of older children begins with some physical exercises similar to those of a gym hour in school. Then they play a competitive ball game. Afterwards they sit down as a group and do some regular class work. Eventually, when the children of the group have become acquainted with one another and with their group leader, some free conversation within the group is started, so that the individual children can express opinions, feelings, and ideas, and can react to one another and to the group as a whole. This program may take about one and a half hours. The group of younger children has, of course, a different program, more of a kindergarten character. The procedure is similar in principle.

The evaluative process progresses during this period of "free observation" as the character and the difficulties of the child unfold themselves. The child is compelled to react to all these diverse, new, or familiar stimuli. Somewhere in the course of the morning, he shows himself doing or displaying something that is unexpected or unusual, that raises a question, gives a clue, and perhaps even is pathognomonic.

The staff of the Hp. learned to realize that it is unpredictable at the start which group situation will produce the diagnostic clues for the difficulties and problems of a particular child. Nothing is known about him in the morning when he and his parent arrive at the clinic. Most likely he is in suspense and feels anxiety or resentment as to what may be in store for him. A strange adult approaches him, encourages him to leave his parent and to join a group of boys

and girls in a variety of activities. He is asked to use his body in some well-defined physical exercise, and to adjust it to the common rhythm of a disciplined group; then to join in a free, competitive sport game; then to work in a classroom situation for a little while; and eventually to participate in an improvised free-group conversation.

These are most provocative stimuli. One has to witness such a morning in order fully to understand how revealing it is of the individual behavior, attitudes, sensitivities, assets, and weaknesses of a child. Gross abnormalities, be they physical, emotional, or intellectual in character, quickly make themselves known. Quite a few cases (and especially those that are the thorn in the flesh of child-guidance clinics) can be spotted and at least tentatively diagnosed during this period.

Also the other, less conspicuous children cannot help reacting in their specific individual ways to that variety of stimuli. Somewhere along the line their behavior becomes significant or symptomatic. The revealing reaction may occur during the separation from the parents, or in relating to the group leader or to the other children, or in response to the demand for discipline. A child may show some peculiarity of motor behavior, may make some revealing remark or answer to a question; he may react with some unexpected affect or may relate to people in some specific manner.

This enumeration is, of course, not complete at all. It is up to the group leader to see and to be sensitive, to understand or to be puzzled, then to react both helpfully and searchingly. He tries to react as best he can to an unexpected reaction in a child. The child, in turn, answers with some reaction that is also a message telling the observer whether his interpretation of the child's first reaction was right or wrong. He has to answer in turn, and so on. Thus the diagnostic (and therapeutic) process is kept going and is pushed as far as is possible and advisable under the circumstances.

While these group activities are going on, other staff members who are not involved in them begin early in the morning to work with the individual parents. A brief history is taken. The problem as seen from the point of view of the parents is formulated, and one discusses briefly with them what they expect from the visit to the clinic and what the

clinic can and cannot offer them. (American psychiatrists who visit the Hp. are just as astonished at its relative lack of interest in parental attitudes and parent-child relationships as the staff of the Hp. is puzzled about the disinclination of American psychiatrists to see, and to work with, children in everyday situations; both sides maintain that the other party fails to see what is the most important.)

At some point of intermission in the group activities, the staff members get together for a quick, informal conference in which they share their knowledge and impressions about the individual children, raise questions, and then decide what further diagnostic methods will be necessary in order to come either to provisional or to definite evaluative conclusions to-day. Work with individual children also is started early. Intelligence tests and achievement tests are given if necessary (often in very abbreviated form, and always individually adjusted to the questions raised in this particular case). A quick, orienting physical examination is given every child. A psychiatrist eventually examines him and talks his problem over with him. This same psychiatrist eventually discusses with the parents the problem as it is seen now at the end of the day's work, and he suggests further diagnostic and therapeutic steps. Often he also discusses the case consultatively with the social worker or teacher or whoever else referred the case and is present.

This is, very briefly sketched, the procedure of a morning in the out-patient department of the Hp. The dangerous pitfalls of the method are obvious. Such an apparatus has to be carefully thought out and organized in all its details in order to function without confusion or misunderstanding, and without committing many blunders. It has to have a very large, well-trained, broadly representative staff. It has to be unflagging in self-criticism and to recreate and reorganize itself constantly in order not to deteriorate into a quick, superficial diagnostic mill, intent on routinely dispatching its many clients.

It is obvious also that this method would be dangerous unless clearly recognized for what it is—a first approach to serious child psychiatric problems. In some cases, it is true, their solution is immediately obvious. In others, it is possible to outline a provisional plan of treatment, and to initiate it.

In many other cases, one can only raise and formulate questions, and outline the first diagnostic steps to be taken toward their answers. It is obvious, too, that such a service would not be good if it existed in isolation, without the background of other child psychiatric services ready to take advantage of the preparatory work of the clinic and ready in each case to take over where limitations of the clinic set in. An all-purpose clinic does not make sense unless it is also a distributional center for the other child psychiatric services of the community.

Before describing how this distribution is done by the Hp., the author wants to remind the reader once more of the great differences between American and Continental psychiatry. In this paper we are interested in the basic principles of the method rather than in its details. The latter depend on the locally prevalent psychiatric and psychotherapeutic concepts and points of view, and on the organization and philosophy of the welfare institutions that form their background. They are bound to vary from community to community, let alone from continent to continent.

The word, *"Heilpaedagogik,"* from which the Hp. derives its name, is in use throughout Central Europe. In a way, it is the equivalent for the American term, "child guidance." However, *Heilpaedagogik* means in literal translation something like "treatment through bringing up" or "treatment through education." Central European *"Heilpaedagogik,"* accordingly, focuses its therapeutic endeavors on working in everyday situations, in a family-like setting, in a children's club, in a children's institution, in the classroom, and so on. American child guidance, on the other hand, is interested mainly in the treatment of the child and of his parents through the establishment of a direct relationship between the therapist and his patient.

The main resources on which dependence is placed in further work belong to the Hp. itself. The outpatient setting itself is used in some cases as the milieu in which to carry on the work of further diagnostic clarification and of further therapy. Formerly it used to be reserved one morning each week for this more intensive work with fewer children. I do not know whether this is still the case.

Another group of children, selected partly from the clientele of the outpatient department, come together as a club one afternoon each week—a group-therapeutic undertaking, according to our definition. There are separate clinics for specific learning difficulties, also drawing their clientele mainly from these two morning dispensaries.

What we have described of the Hp. so far is only one important part of it. Its inpatient department is of equal importance. The one could not exist without the other. It would take us too far from our main topic if we tried to describe here the organization and the functioning of this old *"Beobachtungsstation"* (observation center), what it tries to do, what it can achieve, and what its limitations are. I only want to express as emphatically as possible my conviction that one needs such an observation and treatment center as part of any central child psychiatric facility. It is truly a pity that there are so few of them in this country, so that most child psychiatrists do not even know what they are missing by not having them. A few modern child psychiatric treatment homes have been created during the last few years.

Seen merely from the point of view of the Hp. outpatient department (or of any other all-purpose clinic), the inpatient department has to serve as an important safeguard. It has to take responsibility for (1) those serious, diagnostically ill-defined cases that one cannot hope to clarify otherwise; (2) cases of immediate emergency—for instance, manifest, threatening, or suspected psychotic conditions, or conditions that bring danger of injury to the child or to others (suicidal and homicidal tendencies), cases in which the behavior of the child provokes maltreatment, and so on; (3) cases that, although diagnostically fairly clear, demand a specific therapy that can be carried out only on a twenty-four-hour-a-day basis. The significance of such a safeguard and therapeutic resource can easily be appreciated.

There is no child-guidance service and nothing resembling such a service at the disposal of the Hp. It is a grave and consequential deficiency. Addition of such a facility would mean the opening up of an urgently needed resource for many cases. It would not offer insurmountable organizational difficulties, once the difference in the function of the two services has been understood. The child-guidance units in

an American child psychiatric center certainly would not be a mere addition to the all-purpose clinic. The triad—child-guidance units, receiving and treatment home, and all-purpose clinic—probably would be coördinated, forming together the core of a new service on a higher level of integration.

The next and last set of therapeutic resources at the disposal of any centralized child psychiatric facility are the services available in the community, but not under the direct administrative influence of the clinic. Case-work treatment and foster-home treatment are little known in Central Europe. In pre-war days, the staff of the Hp. laid much emphasis on the development of many and good institutions in and around Vienna. These institutions were encouraged to develop specific functions and to serve specific therapeutic needs. The staff members of the Hp. visited them frequently or regularly, knew their staffs and many of the children there, and had some influence on their methods. The institutions, on the other hand, used the Hp. for various consultative purposes. Proper intake was one of them. Thus the institutions became to some degree part of the therapeutic apparatus of the Hp.

The relationship of the Hp. to the system of public-welfare agencies of the city was undeveloped beyond working relationships with individual social workers. That same problem of the relationship of such an all-purpose clinic to the private and public welfare agencies of the community would be a matter of prime importance in this country. A great deal of thought would have to be given to the question how the clinic could serve those agencies, and how the agencies could be drawn into active participation in the work of the clinic. After all, every morning of such outpatient service would bring several cases that would best be served in a child-welfare agency, a family agency, a children's institution, or a group-working agency. One might visualize intake workers of the respective agencies participating in the procedure of the morning, not merely as observers, but as active members of the team.

I wonder whether I have driven home some of my points by so sketchily describing the Hp. The following are those that I should like to emphasize:

1. An expansion of our child psychiatric services (and undoubtedly of psychiatric services in general) should take

place on a creative basis rather than by extending and multiplying our already existing, too selective and exclusive services.

2. A multi-functional organization, an all-purpose clinic is possible and necessary. The functional and administrative combination of such an all-purpose clinic with a system of child-guidance clinics and with a child psychiatric receiving and treatment home is by no means outside the realm of possibilities.

3. Such a development would be an important step in the direction of alleviating our pressing problems of "unmet needs," waiting lists, and so on.

4. As a last point, such a development would broaden our outlook in child psychiatry and open up new approaches to our therapeutic problems and research problems at a moment when the heuristic value of our present methods and viewpoints may be approaching the point of exhaustion.

EDUCATION FOR MENTAL HEALTH

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NEW challenges confront the psychiatrist and the educator. Our world is threatened by man's destructive ingenuity, man's distrust and fear, and man's colossal, careless waste of natural and human resources. Psychologist, educator, and sociologist can no longer afford the luxury of ivory towers or philosophers' armchairs. The psychiatrist must come out of his office with its inviting couch, and the teacher must see beyond the confines of her classroom and her textbooks. Together with parents, ministers, and social workers, they must examine goals and the means of achieving those goals. Vast stores of specialized knowledge and skills must be integrated and applied to the primary goal of equipping the children and youth of to-day with the strength, integrity, and mental health that alone can keep vital our democracy. We need protection from our own inadequacies, short-sightedness, and fear-motivated aggression even more than we do from any outside enemy.

Personality development, socialization, maturity, mental health—whichever one prefers to call it—is the corner stone on which rest freedom and responsibility, and these inseparable two are the essence of democracy. The psychiatrist, particularly the child psychiatrist, knows that his major concern is not mental illness, but mental health. The enlightened teacher does not focus primarily on the transmission of facts or skills, but on what those facts and skills can contribute to the total personality development of each individual child or student. An outstanding psychiatrist and educator said recently, "Education is psychotherapy and psychotherapy is education."

What do we mean by maturity or mental health? It is my firm conviction that mental health can be defined only in terms of the cultural or social milieu. Attitudes, reaction patterns, and behavior that are normal and healthy for a Chinese youth would not be normal and healthy for a lad born and bred in Denmark. The mentally healthy geisha girl's attitudes and

way of living would be regarded as highly abnormal in a convent school. The child educated for service to a totalitarian or hierarchical state is not emotionally, socially, or mentally prepared to live happily and usefully in a democracy. He is confused by freedom and understands responsibility only as the power to impose on others. Our mutual concern is how to achieve mental health, maturity, and integrity for the future builders of democracy.

Let us examine a few of the chief components of mental health in this our culture—the things that we as parents, teachers, psychiatrists, social workers, and citizens aim to make available to our children in the long educational period from infancy to maturity. Health and happiness go together. One is dependent on the other, but mere indulgence in the pursuit of pleasure brings neither health nor happiness. Our aim must be to help the child or the youth to develop the capacity to find rich satisfaction in working and functioning usefully and up to the limits of his individual endowment and potentialities. To do this the parents and the teachers must know what are the child's individual aptitudes and what are his particular limitations.

Here the clinical psychologist has much to contribute. The child's changing interests and motivations must be given consideration. The meaning to him of the material presented will determine its value in his development. Our greatest educational blunders—blunders that in many cases have produced psychic trauma—have consisted of forced feedings of meaningless material. We see this most clearly in children with reading handicaps. Education should stimulate and motivate the use of the knowledge and skills it is providing.

The gifted teacher guides youth to the discovery of the satisfactions of intellectual effort and mastery or exploration. She transmits to youth the skills that can open the way to deeply satisfying creative expression. Learning to savor the gratification of completing successfully a tedious task is an educational experience that leads toward mental health. Extracurricular activities do not deserve a second-class rôle in an educational program directed toward the development of the total personality. It is through athletics that the student may discover the joy of full physical effort and motor and sensory coördination. In group or club activities, he not only

learns how to coöperate and how to take responsibility, but also discovers the satisfactions inherent in joint activity and shared responsibility.

We citizens must make it our civic duty to see that all the children in our community have schools and recreational facilities staffed with teachers and leaders imbued with this philosophy—that every child must be helped to discover useful work suited to his capacities, the doing of which, to the best of his ability, will bring him contentment and deep satisfaction while at the same time serving the community or some unit of the community. The individual who works with satisfaction and a sense of doing a needed job—be it fitting cards into envelopes, or research in atomic energy, or caring for a home, or playing in an orchestra—has a sense of security and self-esteem that transcends the fictional pride of ancestors on the *Mayflower,* a listing in the social register, or a big, but unearned income. Self-esteem, based on real values, and security, resulting from a sense of personal worth and usefulness, are important elements in mental health.

But mental health is not only a matter of happiness, satisfaction, and personally achieved social security. It implies also a recognition of and a capacity for adjusting to external realities which, in our present-day world, are subject to kaleidoscopic changes. Education for satisfying and useful performance within a known and safe framework is not enough. Youth must be prepared "to take it" and "chalk it up to experience" in a world of potentially tough realities.

"They loved the child and led him by the hand
Through fragrant fields that knew but rainbowed storm.
They wrapped him tenderly in fleece so warm,
He never dreamed the wind that scourged the land
Drew dark and hungry blood. So well they planned—
With no fierce sting he saw the wild bees swarm;
He stood on mountain peaks, watched great clouds form,
Yet knew no weary trail, slow caravaned.

"Then came the sudden day they said, 'My son,
You are a man, well-bred, well-taught, full-grown.
We gave you all we had. Our task is done.'
They opened wide a new and unguessed door.
He saw snow swirl, heard wolves and tempests roar.
He went out naked, weaponless, alone."[1]

[1] "They Loved the Child," by Frances Hall. *The Saturday Evening Post,* Vol. 213, p. 46, September 21, 1940. Reprinted by special permission of *The Saturday Evening Post.* Copyright, 1940, by the Curtis Publishing Company.

Strength lies in flexibility, not in rigidity. I do not mean that goals should shift with changing circumstances, but rather that the individual should have the freedom and the ingenuity to adjust his methods of achieving goals to new and unforeseen reality factors. Training and education for adjustability and flexibility are even more difficult than education for satisfaction and usefulness, perhaps because they run counter to our deeply ingrained conservatism. The tendency to repeat patterns of reaction and patterns of behavior until they become automatic is a fundamental biological and psychological law. Psychologists call this tendency the "repetition compulsion."

An automatic mode of functioning or of reacting to stimuli has obvious economic value from the point of view of psychic energy. In order to function effectively—even in order to function at all—it is essential that most of our routine everyday activities be accomplished automatically. For example, the small child, with his primitive impulse to explore and master his environment, will reach toward and grasp a lighted match. He recoils in pain, and after a few such experiences, the painful memory causes him consciously to inhibit the impulse to grasp the lighted match which arouses in him objective anxiety. The inhibition of the impulse to grasp soon becomes automatic, without the painful memory image and without anxiety. The automatic reflex inhibition contains all the wisdom embraced in the psychic process for which it is a substitute. It is not only an efficient saver of energy and time, but it is a protection against the anxiety that accompanies the painful memory image—in this case associated with the impulse to grasp the lighted match.

Many of the child's primitive impulses for mastery, domination, aggressive expression, and self-indulgence either run counter to the restrictions of reality or are unacceptable to the loved ones in his environment. Obtaining pleasure by carrying out these impulses brings painful consequences, often in the form of punishment by his parents on whose good will and love the child feels entirely dependent. To avoid the threat of punishment, the child develops automatic defense reactions against his own instinctive impulses. The three-year-old child may, in jealous desperation, long to get rid of the new baby—to make it go away or be dead. He longs to

pound it or to bite it. But he does not dare to indulge this wish for fear of retaliative punishment by his mother and father, who for some reason treasure this absurd and useless new object. So his impulse finds only partial, distorted, or attenuated expression. He spits in the baby's face or pokes it. The baby cries and he is punished and called a bad, bad boy.

As he grows older, he recognizes that even the wish to destroy an object of such worth to his mother is naughty. The presence of the guilty wish creates anxiety. Early in life the child learned that badness is paid for and wiped out by punishment. Guilt and its consequent anxiety can be relieved by suffering or punishment. As the child takes into the structure of his personality the moral and ethical values of his milieu—as he develops a conscience—he takes over the parental rôle and punishes himself for forbidden desires, as well as deeds. His punishment may be accomplished in symptoms or actions that bring him guilt-relieving pain, but that at the same time represent a gratification of the forbidden impulse. For example, the boy who longed to strike and kill his baby brother, but who merely spat at and poked him and later only wished him ill, may develop tics involving his face and arms. The tics which are symbolic gestures of aggression are a humilating form of self-punishment, but at the same time the boy is spared all knowledge of his wish to destroy his brother and of his guilt and anxiety at harboring such an impulse. A rigid, symbolic automatic pattern of behavior is compulsively repeated long after the situation that occasioned it has become insignificant.

Most automatic reflex inhibitions or repressions take place in childhood, and as the child grows older, an alteration of circumstances always occurs. The adult does not need to condemn all the behavior reactions repressed as a child. To return to our example of the lighted match, it is imperative that the older child or adult be the master of fire. The modern child learns to control fire first by blowing out Mummy's or Daddy's match, then by lighting and extinguishing fires. He can appropriately respect and use fire only if his capacity for reality experience is not limited by rigid archaic or anachronistic patterns of reaction. An imperviousness to the effects

of later experiences with reality is one of the most important conditions for the development of neurosis or character disturbance. A neurotic symptom is essentially a repetition of a reaction pattern that once served a useful purpose, but that is no longer sensible—like Lady Macbeth's hand-washing.

Behavior problems, symptoms, learning inhibitions, and crippling personality traits have their origins in childhood. They are patterns of reaction that become more automatic and more rigid with repetition and more and more out of line with reality as time passes. An educational system—and I include both the family and the school—that aims to prepare individuals to meet whatever vicissitudes life may present in a rapidly changing world must hold to the goal of helping every child to deal adequately and independently with as wide a range of reality experiences as can be offered. Much has been written and said about giving the child security and protection. But his greatest bulwark against anxiety and suffering will be resiliency and a joy in challenge.

"I tell you this to your bright, sweet face,
Our world is a most precarious place.
Let others teach you to long for a surety;
I will train you to know and accept insecurity.
Since you cannot keep life inside a neat fence,
You will learn to lean on impermanence.
You will cherish love and prize all beauty,
Tho it break your heart and end in duty.
You will not fear ecstacy's turn to disgust,
You will walk like a lion after crawling in dust.
The ultimate weakness will make you more strong.
You will say, 'What was right is now become wrong.'
You will sow for joy and reap in sorrow,
But never surrender your wish for to-morrow.
You will take delight in the indrawn breath
That gives you life which leads to death.
I want to wean you from the womb.
Come out, my child, from that warm, dark room.
You will not find its like this side of the tomb."[1]

The child can best develop ingenuity when he is in a flexible home and school, where he is challenged with real problems. When his capacity to cope appropriately with reality require-

[1] "For a Child," by Irving Fineman. *The Nation*, Vol. 140, p. 705, June 19, 1935.

ments becomes blocked, so that his intellectual or social development is restricted, it is time to call in the services of a guidance consultant. The dynamic background of uneconomic reaction patterns must be understood before an effort is made to suppress a particular symptom. Punishment, bribery, and pep talks could never cure our boy with tics. Only when the boy himself ceases to feel guilty because of his infantile jealous death wish toward his baby brother can he relinquish the symptom.

Mental health is happiness in doing useful work commensurate with one's capacities and doing it well. Mental health is flexibility, so that changing circumstances can be met with appropriate reaction patterns. Unresolved conflicts of childhood must not inhibit adjustment to adult realities. A passive acceptance of reality is not enough for the free and educated citizen of a democracy. It is the high responsibility of the educationally privileged to take an active share in the creation of our cultural realities. This is a responsibility that our educators and professional men and women have been loath to assume. We have left lawmaking to the politicians and responsibility for economic conditions that affect us all to labor leaders and to vested interests. Education for maturity in a nation governed by laws rather than by individuals must develop respect for laws, so that they will be obeyed. But in a free and healthy nation individuals must also be prepared to take the responsibility for making good laws and defeating or repealing bad laws. To remain healthy, a democracy, like an individual, must have the flexibility to meet changing conditions. Our educational institutions, from the kindergarten to the university, must stimulate the individual to accept his social responsibilities and equip him with the knowledge and skills to carry them out. Adjustment to reality is an active process, not merely a passive acceptance.

There is one more important element in emotional and social maturity which is perhaps an obvious derivative of what we have already discussed. Normally, the young child's greatest joys come from direct personal gratification. His relationships to people are characterized by his dependence on them. Parents and teachers give and he receives. His orientation is toward himself, and we call him selfish, demanding, or

ungrateful. I once heard the head master of a boy's school remark, "Whenever I hear of altruism in a boy under twelve, I'm suspicious. If you examine the incident closely enough, you find that what the boy was out for, was himself. If you can't find anything, then you had better watch out. There's usually something wrong with the boy. Altruism comes later."

Without altruism, there cannot be maturity or mental health. The adult must find deep satisfaction in giving to social and love relationships. Joy in giving transcends the selfish gratification of purely personal desires. In it there is fulfillment of self-needs and of the needs of others. The steps from narcissum to altruism are the most important in the whole educational process, and they are the steps least accessible to influence by formal academic procedures. You can't preach or teach people to find gratification and joy in the old precept, "Love thy neighbor as theyself."

The psychiatrist cannot and should not try to tell the teacher how to teach. But he can contribute to the teachers' and parents' understanding of the learning process. Education for adjustment in the home and in the community begins in the first years of life. The young child truly makes a part of himself, not what he is told or taught, but the emotional climate and attitudes that surround him.

"There was a child went forth every day,
And the first object he look'd upon that object he became
And that object became a part of him for the day or a
certain part of the day
or for many years or stretching cycles of years. . . .

"His own parents,
He that had fathered him and she that had conceived him in
her womb and birth'd him,
They gave this child more of themselves than that,
They gave him afterward every day—they became a part of him.

"The mother at home quietly placing the dishes on the supper table,
The mother with mild words, clean in her cap and gown, a wholesome
odor falling off her person and clothes as she walks by,
The father, strong, self-sufficient, manly, mean, anger'd, unjust,
The blow, the quick loud word, the tight bargain, the crafty lure,
The family usages, the language, the company, the furniture,
the yearning and swelling heart. . . .

"These became part of that child who went forth every day,
and who now goes, and will always go forth every day."[1]

[1] From *There Was a Child*, by Walt Whitman.

The personality grows and develops by a process that psychiatrists call identification. This consists of an incorporation into the self of the personality attributes of those adults who surround the child or youth and who have meaning for him. The jealous three-year-old boy we referred to earlier absorbed from his mother the knowledge that it was wrong and bad to hurt or even to want to hurt the younger brother. As time went on, he learned from his oversevere and punishing parents that a guilty deed or wish must be absolved by punishment. His inner sense of morality, his ethical attitudes, and his conscience were derived from those of his parents. When, in later life, feelings of hostility or aggression were aroused, he reacted as if his parents had said, "That's bad. Now you must be punished." In response to the guilty feelings mobilized by aggression, he punished himself with tics, which at the same time allowed distorted expression of his hostility.

The learning process, in so far as concerns attitudes toward personal feelings, toward other people, toward responsibility, toward knowledge, toward everything, is essentially a matter of identification. It is apparent that the quality of the personalities who surround and teach our children from infancy through adolescence is of primary importance. The quality of these people is what counts in character development. Education in its broadest sense includes the subtle, unconscious process of identification as well as horizon-widening experiences, the development of useful and satisfying vocational skills, and a full awareness of reality.

We cannot select mature, healthy, and inspiring personalities for parenthood. The most inept, the emotionally and intellectually childish, and often the mentally sick reproduce with uncontrolled fertility. Until democracy discovers some method of population control, that is a reality we have to accept, recognizing that it is one of our challenging problems. But though we cannot select parents, we should be able to select teachers. The good and the well-endowed school and college can and should try to select teachers who not only can teach their subject matter, but who are also mature and mentally healthy men and women. The great teachers whom we remember from our youth are the ones who influenced us

more by what we took into ourselves from their personalities than by the facts they taught us. The facts we are likely to have forgotten unless we have recurring need for them, but attitudes toward facts and toward many other things have become a permanent part of us.

The problem of wholesome teacher personality is particularly pertinent in our public schools, where the majority of our citizens are educated. In many, many cases it is here that the children of inadequate parents have their only chance of establishing wholesome personality-building identifications. But we as citizens are profoundly apathetic and shortsighted and pinchpenny. We do nothing to attract able and mentally healthy young men and women into public-school teaching. We seem to go out of our way to make the position of the public-school teacher as intolerable as possible. Public schools cannot select teachers on the basis of personality aptitude. Too often they have to take what they can get. A neurotic, frustrated, or dissatisfied teacher, with thirty to forty children in her classroom, can hardly be expected to make up to those children for the defects in their parents' personalities. The problem of the public-school teacher is another challenging reality for the mature citizens of to-day and to-morrow.

To produce those mature citizens, teachers must teach children, not courses, and psychiatrists must treat children, not symptoms. Parents must seek to convey attitudes rather than manners to their children. There is truth in the old axioms. "Politeness is to do and say the kindest things in the kindest way." "Love thy neighbor as thyself." "Do for others as you'd have others do for you." But even the best precepts are learned only by example. To hollow words, youth replies, "Oh, yeah?"

Teachers, doctors, and parents can boast maturity only when they recognize intellectually and accept emotionally the fact that learning inhibitions, neurotic symptoms, and behavior problems are the best compromises that the individual child or adolescent can achieve under his particular constellation of circumstances. In self-defense, the child must try to find satisfaction and he must try to avoid pain inflicted by the outside world or anxiety stemming from a sense of guilt or

inadequacy. His unacceptable behavior or his symptoms are automatic repetitive patterns which originally served as a meaningful compromise, but which have become not only absurd, but so uneconomic of psychic energy that the child's development is halted. It must be the goal of the psychiatrist, the educator, and the parent to set every child free to develop to the limit his potentialities for his own satisfaction and for the good of the community.

PRINCIPLES AND PRACTICES USED IN CHILD PSYCHIATRIC CLINICS*

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PSYCHIATRIC clinics for children, or child-guidance clinics, have developed in this country over the past thirty years as a result of two important tendencies. The first was the movement, instigated by such leaders as Dr. Adolf Meyer, Dr. E. E. Southard, and Dr. Frankwood Williams, which encouraged psychiatrists to emerge from mental hospitals and to interest themselves in less severely ill patients and in community problems. The second tendency, that of focusing the interest of psychiatrists on the psychiatric problems of children, was stimulated by Freud's demonstration of the importance of the early years of life in the formation of character traits. Dr. William A. White emphasized this when he coined the phrase, "Childhood is the golden period for mental hygiene."

The Psychiatric Clinic of the University of Maryland operates on the basis of the teamwork of three professions—psychiatry, psychology, and psychiatric social work. In the usual study of a child, the psychiatric social worker, in a series of interviews with one or both parents, studies the child's history and environment, stressing particularly the emotional environment as evidenced by the attitudes of parents and other important people. This study enables the social worker to make a workable diagnosis of what disturbs the parent-child relationship and an estimate as to how well the parent can respond to, or make use of, clinic treatment. The clinical psychologist gives the child a group of selective tests which throw light on the child's assets and reveal any unevenness in intellectual development and any psychological blocks to learning. Psychologists develop and apply many therapeutic skills that are very useful in certain types of case. The psy-

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chiatrist interviews the child and studies his attitudes and reactions to the problem as well as his contribution to the disturbed parent-child relationship. Thus the psychiatrist is able to make a diagnosis of the basic psychodynamics involved as well as an estimate of the child's probable response to therapy. Physical factors are studied either by the family physician or the pediatrician or by a pediatric clinic. Usually these various studies are pooled at a conference at which a dynamic picture of the genesis and development of the problem can be synthesized and an appropriate plan of treatment evolved.

Let us turn to some of the special methods used in examining and treating children. We have learned that successful psychiatric treatment depends on a patient's desire for help and willingness to talk about his problems. In this respect it is easier to treat adults than children. Ordinarily, in an outpatient clinic, the adult wants and asks for help whereas the child seldom does. Usually it is an adult who wants the child treated—a parent, a teacher, a social worker, or a judge. In fact, children are so confused by the fuss stirred up, and so frightened by the idea that there might be something wrong with them, that they initially feel opposed to being examined or treated in a clinic.

This negative attitude is frequently fostered by scenes at home. One boy eventually told me that his father had announced that I was going to cut his head open to find out why he stole. Several children have described some such scene as this: The mother came to the supper table one day announcing that the school principal had advised her to take her child to the psychiatric clinic. Whereupon the father roared, "What does she think—that Johnny is crazy? You tell her she's crazy. No psychiatrist is going to examine my boy." In spite of this, such cases often get to the clinic eventually. This initial negative attitude on the part of the frightened child makes him decide either not to talk at all or to be very guarded in what he says. Coupled with this is the fact that children between three and ten years of age, or even older, find it very difficult to verbalize.

These difficulties have forced us to adopt certain techniques to overcome the barriers that tend to prevent successful therapy. The most obvious step at first is to gain rapport.

This can be achieved by the therapist's showing a friendly interest in the child, trying sincerely to understand and appreciate his feelings, and adopting a neutral, non-judgmental attitude toward his disturbing behavior.

Play therapy is also useful in gaining rapport with children. In my office I have a cupboard with a wide variety of play materials—crayons, paints, clay, dolls, doll furniture, soldiers, trucks, toy cannon, pistols, and rubber daggers. I invite the child to choose something to play with and suggest that he make up a story about what he is doing. Play is the universal language of childhood. Through play children can freely express their feelings both directly and indirectly. An example of indirect expression is a boy who had a mother doll punish a boy doll and then made the boy doll attack and beat the mother doll furiously. In this play he was hiding behind the anonymity of the doll, thinking that he was not revealing his own feelings.

Play therapy is very different from play as we usually see it. A child plays one way when he is alone, another way when he has a companion, differently in a group, and still otherwise with adults. When he comes to a clinic, he knows that his parent hopes something will be achieved by it. Every child craves to be understood, but at the same time resists the process. In therapy a child will often repeat the same play over and over, until finally the doctor catches on. I have frequently had children call my attention to what they are doing. Thus a ten-year-old boy, after a violent attack on the father doll, turned a toy pistol on himself and said, "Look, I'm shooting myself. Isn't that a crazy thing to do?" A five-year-old boy, who had developed a dependent rapport, called my attention to a slip of his tongue, saying, "Did you hear me then? I called you 'Mother.'"

Through play a child can express a wide range of phantasies, attitudes, and feelings. Shy, inhibited, neurotic children are able to achieve a remarkable release of pent-up emotions in their free play and in time come to understand and express their feelings in a more healthy manner. Thus, I treated an extremely shy, polite, and excessively docile ten-year-old girl who was referred to our clinic because of neurotic pains in her abdomen, accompanied by nausea. In the five months before she was referred she had missed twelve weeks of schooling

because of her illness. In her play she repeated many times the theme of men attacking and hurting women, who became sick and were taken to the hospital. Later, she was able to discuss phantasies and fears she had had about sexual assault. No matter what psychological school of thought one may believe in, the real point is that all during a four-month period of treatment, she was symptom free and she missed no school. This improvement continued for a year, the only follow-up we have attempted.

This leads me to discuss briefly some of the principles we have found to be valid in child psychiatry. I wish to say first, regarding our teamwork approach, that we get our best results when some one interviews a parent every time the therapist sees the child. The purpose of these interviews with the parent is to get him to observe himself and to discover a connection between how he feels and acts and how the child behaves. Almost routinely, children improve therapeutically as soon as the parent gains some insight about himself.

The ultimate aim of any psychotherapy is that both therapist and patient have a true understanding of the meaning and motivation of the patient's symptoms and behavior. Direct treatment with the child can be divided into three phases. At first an attempt is made to gain rapport by the means I have already described. In this early, getting-acquainted phase the therapist tries to encourage the child to express himself spontaneously, verbally or in play. The therapist intrudes his own ideas very little. He is learning how the child thinks and feels. When the child expresses some feeling, this is commented on just to let him know that we are paying attention and trying to understand. Sometimes, even though the child expresses no emotion, we are able to guess from what he tells us that he should have felt angry or been afraid. We tell him this by some remark, such as "I guess that made you pretty angry." As much as possible we try to avoid "why" questions. When a child does something, if we ask him why he did it, he becomes upset and disturbed. In the first place, he doesn't know. In the second place, he feels the question as a test and wonders what we expect, or what we think is the right answer.

This first phase merges imperceptibly into a middle phase where most of the treatment is accomplished. In this phase

we are able to discern certain patterns of behavior that we can talk about more freely if rapport is good. During this period the child is busy testing us out. Most disturbed children have suffered from inconsistent handling. They crave to find some one who is consistent and whom they can count on. In our office we set definite limits to what the child can and cannot do. This makes him feel safe and less anxious, but at the same time he keeps trying to see if we are really consistent. We discover in this phase other repeated tendencies. Thus he often tries to stimulate us to act just like one of his parents. At this stage in his treatment the child expresses his pent-up emotions. We help him do this without feeling too guilty or anxious. We reassure him about the naturalness of his feelings and we sometimes dilute the dosage by not encouraging too much release at one time. We also discuss the meaning to him of his feelings.

This middle period merges imperceptibly into the terminal phase, which is characterized by freer verbalization. This phase is more educational. The child, by this time, has expressed his confusions and is practically asking for enlightenment and insight. Many of these children suffer from ungrounded fears, unreal notions, and distorted ideas which can now be profitably discussed. It might seem logical and simpler to by-pass most of the therapy as I have described it and at the start of the treatment to tell the child the facts about himself and his life. Unfortunately, we have learned that such early discussions have no effect on the child's problems. Both the doctor and the child must discover the problem and its meaning before such a discussion is fruitful.

Our diagnosis usually reveals some variation of this theme; the emotional growth of the child has been blocked by a variety of circumstances, often involving a parent-child tangle that has developed the character of a vicious circle. In treatment we attempt to clarify and untangle the situation so that the spontaneous tendencies toward growth, inherent in every child, may proceed relatively freely. In other words, we attempt to free the child from the internal, as well as the external, conflicts that have interfered with his emotional development.

I will illustrate by describing briefly the case of a small boy treated in our clinic by a woman therapist. The child,

referred because of pretty severe personality and behavior problems, was treated in the clinic in weekly visits for about a year, the mother and child participating in the treatment situation.

At the time he was referred, the patient was four years, ten months old, and had just been dismissed from an excellent nursery school because of his destructive behavior. He was noisy, demanding, dominating, and intensely hyperactive. He was cruel to animals; he threw a dog downstairs, and was cruel to a cat, which he loved. At home he lied constantly and took money. He cut up sheets and towels with razor blades and threw things out of the window when left in his room. This child "fought off" sleep, and there were always scenes at bedtime that lasted several hours. His parents were unable to control him, and he was destructive in the neighborhood. He shot a BB gun through windowpanes, and destroyed flowers in a neighbor's garden.

Before his birth the mother had been quite ill, had had rheumatic heart trouble, and had not expected to survive this pregnancy. The patient had weighed eight pounds at birth. He had been breast-fed, with supplementary bottle feedings, and had gone on to bottle feeding easily. He had been active from birth. At three months of age, he had had colic with some temperature. Otherwise his health history had been uneventful. His development had been precocious. He had walked and talked early, and at the age of two had been using long sentences. Bowel control had been established at two and one-half years after a tremendous struggle with the patient, who, even after using the toilet, deliberately soiled himself four or five times a day, and smeared himself, the wall, and the furniture. Bed-wetting and soiling had been cleared up, however, by two and one-half years and had not recurred.

The patient was a feeding problem in that he created a fuss and disturbance at mealtimes. He was, at almost five years, somewhat undersized and, when quiet, looked rather frail and tired. He had a tonsillectomy during the period of treatment.

The boy had been seen in another psychiatric clinic at the age of three years, and the mother had been told that he was subnormal and would probably become a criminal. She had been unable to accept the diagnosis of subnormality and had

developed some hostility to psychiatry. She came to our clinic at the suggestion of another mother, whose child had been treated successfully.

The father, aged forty-three, was well educated and came from a home of good middle-class standards. He was described by the mother as a quiet, stable sort of man. The mother, throughout the contact, denied any serious marital maladjustment. She was thirty-three, a high-school graduate, had a rather explosive temperament, and was quite desperate about the patient's increasing behavior difficulties, with which she could not cope. One other child, a girl seven years older than the patient, was a withdrawn, submissive child, who created no problem at home or at school. The mother frequently expressed extreme hostility toward the patient, with marked guilt, admitting that she often wished she had never seen this child. The patient was constantly punished by both parents. Once, early in the treatment period, the mother tied him hand and foot to his bed with a rope. She wanted, and investigated the possibility of, military-school placement for him at the age of five years.

The patient was tested in the clinic, and at the age of four years, ten months, he was exactly one year accelerated intellectually, with an I.Q. of 121. He showed very superior ability also with tests of the puzzle type. In the test situation he coöperated perfectly and displayed none of the problems described. All subsequent contacts confirmed his superior intellectual ability. His vocabulary and range of interests were well beyond his actual age. He was not above average in manual coördination. His hands were small, and he was awkward and careless with them, frequently breaking and spilling things.

The mother was seen by the psychiatric social worker each time the patient was seen for treatment interviews. The mother resisted her part in the treatment process. Although she knew that the patient was bright, she clung to the idea that he was abnormal, and for a long time could not see any possible relationship between her attitudes and the patient's problems. Her treatment was interrupted by a change of social workers, and there was a period during which no one saw her. She was, however, quite regular about bringing the patient, although at first she was greatly discouraged as

no improvement occurred. In each interview she would recount the patient's outrageous behavior of the current week, showing great hostility to the child, and resisting any effort to come to grips with any part she might have in his problems, although she quoted the patient as saying to her frequently that she did not love him.

Both parents wanted the child placed away from home for treatment and observation, and the mother kept coming back to the question of boarding school. She also referred constantly to her own nervous condition, which she felt was greatly aggravated by the patient's behavior. Attempts were made to get her relaxed and working on the problem of her relationship with the child. During the period when she was seeing no one herself, she was impatient and bored, would buttonhole the child's therapist and express her hostility and discouragement in a kind of temper outburst, often in the child's presence. With the second social worker, she was brought back again and again to the problem of her own attitudes and what they were doing to the patient, and concurrently visible improvement occurred in the child. Toward the end of the treatment, the mother's attitude was much more relaxed. She had really seen the connection between her own attitudes and the patient's behavior. She began to show some pride in the child and to appreciate some of his boyish qualities.

The patient knew from the start that his therapist liked him and felt that he was all right. This made him anxious to hold this regard and his behavior at first was quite controlled. He always remained anxious to have the therapist think well of him, and always became disturbed if the therapist so much as spoke to his mother.

As he was quite young, it was not too practicable to talk to him directly about his problems and most of the hours were spent in spontaneous play. Early in the contact, there were two or three interviews in which he treated dolls representing a family with great hostility. He put them all in bed and said that they had broken their legs. He "scalded" the doll representing the mother in the toy bathtub and threw her in a puddle on the floor. He shot the dolls representing father and mother. He announced that his sister liked to play with matches and had "burned herself to a cinder." On another

occasion he fabricated that his sister had pneumonia. He had reason to be jealous of his sister, who was obviously acceptable to both parents. He was not questioned at all about how his parents treated him, and all this hostility was directed toward the dolls anonymously. They were never identified as his own parents.

As the patient became more secure, he went into a second phase. He became very aggressive and destructive in the office. He spilled water, broke toys, scattered toys all over the place, was noisy and hyperactive. This was permitted within certain limits, as with a child so disturbed it seemed necessary for him to learn that some one could still like him even if he was bad. Usually he became anxious if he was really destructive and made some bids for reassurance. He would quiet down, come close, and would ask to be read to. As the contact continued, he made more and more bids for direct expression of affection. He sat in the same chair, stood close beside the therapist, and was quiet for twenty or thirty minutes at a time.

About the third month he did several things to suggest that he feared that little girls were better and more loved than boys. Each time this question was brought up in some indirect way, he was given reassurance that the therapist liked boys. Treatment was interrupted for a month by the summer-vacation schedule. He had shown some improvement in the third and fourth months of treatment, but regressed during the summer.

In the fall he was glad to resume contact and interviews were much as before. About this time he began to talk about fears and phantasies, and it became clear that he was afraid to go to sleep at night. He talked of a ghost with an electric knife, and said, "Cross your heart and promise, or you'll die before morning," a phrase that must have been said to him. There ensued several interviews full of phantasies about comic-strip characters. At one point he interrupted and said to therapist, "You love me, don't you?" When asked what he thought, he said confidently, "I know you love me." He brought out a phantasy about marrying the therapist. He brought flowers. He also played being a baby, drinking water from a small nursing bottle.

Treatment now focused on setting up some limits as to

what the patient could do in the office. He was told at one point that it is possible to like some one and yet not like everything that person does. The sessions became more quiet and the patient showed more and more affection. He began to get over his anxiety about being a boy and showed a lot of playful domination of his therapist. His relationship with his mother improved, and toward the end he told the therapist that he liked his mother best. On that same date the patient suddenly said very seriously, "I think I always liked everybody except myself," and, on question, admitted he was beginning to like himself.

At the next interview, he was still preoccupied with that question: "I'm not so sure I like myself. Is it right to like yourself?" He was again reassured and at that point seemed to accept himself. His relationships and behavior outside improved rapidly. The kindergarten reported a great change in him. He gained weight, took on color, and began to sleep normally. The treatment was terminated with plans to send him to a small summer camp, and he was ready and eager to go. The mother and child were told that they might return if things went badly, but they have not been heard from.

This case illustrates several features commonly encountered in the psychiatric treatment of children. First, we observe the vicious circle mentioned above. The mother's rejecting, hostile attitude not only contributed to the child's disturbance, but her attitude in turn was aggravated by the child's destructive and defiant behavior. In this case, as in many other child-guidance cases, treatment is successful only when changes in attitudes can be effected simultaneously in mother and child. At the same time that the mother becomes more tolerant, the child feels accepted by the therapist, even though he expresses hostile feelings. This acceptance is finally turned back on to the parent. With this break in the vicious circle and the removal of the major obstacles, the child's emotional growth can proceed more normally.

YOUTH PARTICIPATION IN A COMMUNITY MENTAL-HEALTH PROGRAM

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THIS report deals with a college classroom project that appears to have values not only as a pleasant educational and possibly therapeutic experience for its participants, but also as a device for promoting youth participation in community mental-health programs.

The project took place in the classes in child and adolescent psychology at Hampton Institute in Hampton, Virginia, in the spring semester of 1950. The classes comprised 178 Negro students, divided into four sections approximately equal in size. The classes included both males and females, with a somewhat greater number of females than males. Most of the students were sophomores; a few, upper classmen. All had had at least one preceding course in psychology—a course in educational psychology. The classes met for fifty minutes, three times a week. They were all under the instructorship of the writer. The text used was *Child and Adolescent Psychology,* by Cole and Morgan. It was supplemented by materials of a mental-health nature, as, for example, Preston's *The Substance of Mental Health.*

Early in the course, the students were told that its purpose was not only to help them make their own adjustments to themselves and to others more satisfactory, but also to enable them to help laymen become better acquainted with mental-hygiene principles and practices. A hypothetical "Mrs. Jones" was conceived. Played frequently by the instructor, "Mrs. Jones" soon became one of the major participants in the classroom work. She was conceived as a mother that the students, as future teachers, soon might meet. She was conceived as having no more than a grammar-school education or even less; as very busy, having to work at home and as a domestic; as having several children, ranging in age from a young baby to adolescents; and as being not

always immediately receptive to new ideas. "Mrs. Jones" asked all kinds of practical questions, demanding practical application of theoretical points. Sometimes her questions had to do with helping herself and her children to understand their experiences as members of a minority group.

"Mrs. Jones" at times proved to be quite a source of frustration to the classes. She persistently seemed unable to understand their unintelligible theoretical explanations, especially those memorized from the text and presented almost intact. One day a class made "Mrs. Jones" the object of their hostility to the extent that they asked how she could have had "sense enough to get married." Whereupon, the discussion turned to the classical study of "the Jukes and the Kallikacks." Throughout the discussions, however, emphasis was placed on talking with "Mrs. Jones" in such a way that she would not become hostile in response to the students' own hostile feelings, which were a symptom of their own inadequacies in understanding and communicating materials to her.

Early in the course, the plan was presented of writing pamphlets for "Mrs. Jones," which she could easily read, understand, and find helpful as well as enjoyable. The pamphlets were to be designed by the students, working in groups of no more than six. Immediately upon the presentation of the plan, the students asked to form their own groups. These spontaneous groupings in themselves were helpful because they revealed early in the semester the "isolates," the leaders, and so on in the classes. Some of the "isolates" formed groups that did excellent projects. As time progressed, certain students withdrew from their original groups and formed new groups, even as small as two. Some of these small groups, under pressure of competition with larger groups, did excellent work.

Each group was permitted to choose any topic it desired that was relevant to the course and to plan its investigation and the organization of its materials as it chose. It was suggested that the pamphlets be no longer than 1,800 words, because "Mrs. Jones" would have no time to sit and read for long periods. It also was suggested that the material be presented in 5½ x 8½ inch pamphlet form and as attractively as possible, with use of all the principles of psychology the students could apply. Each group met as it chose outside of class

and, in some instances, during class hours. Each group kept a diary of its activities, and was encouraged to apply psychological principles in its own functioning, and to study itself from the point of view of group psychology. Many of the students' discussions in the unit on the social psychology of adolescence were enriched by accounts of their own project-group reactions. Drafts of prospective pamphlets were submitted to "Mrs. Jones." These she frequently returned with notes that she could not understand what was implied. Some groups visited real "Mrs. Joneses" for help in the matter of word usage.

Before the completion of the pamphlets, the question arose as to how best to present the pamphlets to "Mrs. Jones." "Mrs. Jones" soon advised the students that she might become tired of listening to all of the groups read their pamphlets, or even portions of them, to her. The next decision was to attempt to devise methods of presenting materials to her in a way that she would find both pleasant and instructive. At first some of the groups planned moving pictures, but "Mrs. Jones" reminded them that she had no projector in her school or church. Some groups discussed debates and panel discussions. "Mrs. Jones" did not seem too much interested. Thus the idea finally was conceived of presenting the pamphlet material to "Mrs. Jones" in the form of dramas.

Thirty-eight pamphlets and class presentations dealing with topics in child and adolescent psychology were the result. Almost one-half of the total thirty-eight topics had to do with discipline and sex—ten with discipline and six with sex. Five others had to do with emotions in children and adolescents—for example, fears, anger, temper tantrums. Three each dealt with delinquency and play; and two each, with speech and music. One group collected only sources of information on child and adolescent behavior. The remaining pamphlets concerned the dull child, the bright child, daydreaming, and attitude formation in minority-group children.

One factor that contributed to the "narrowness" in choice of topics, according to the students, was the fact that the project began early in the course when their experiences with the variety of possible topics was limited. Discussions of the chapter on discipline were in progress in class at the time when the pamphlet topics were being selected. There was,

however, other evidence which seemed to suggest that the choice of topics was also, in part at least, related to some of the students' own problems. Several discussions with the instructor after the class dramas suggested this. Some groups indicated they actually were replaying experiences of their own. One student was obliged to leave the presentation of one drama, returning to class at its completion with the explanation that it was too disturbing for him to watch. (This particular drama showed a mother whipping her son.) In the conversation with the instructor that followed, this student revealed emotional difficulties manifest since his war experiences and also indicated his desire for psychiatric help.

Allotted no more than twenty minutes for their class productions, most of the groups presented dramas the first portion of which showed ways of working out parent-child or child-teacher situations that were not in accord with the principles discussed in the course. In the second portion, the situations were conducted in accordance with such principles, or, as one student expressed it, "in the way we wish we had been treated." All the dramas were seen for the first time by the instructor upon their class presentation. Although the groups had been advised not to rehearse their dramas so as to take time from other course work, observations indicated that some groups did play out "Mama, don't beat me" with whippings and very active disruption of furniture before their class presentations. Many of the groups spontaneously indicated how much they enjoyed acting out the dramas, with or without audiences.

Considerable spirit of competition developed between the groups with respect both to the dramas and to the contents and appearance of the pamphlets. In some instances the pamphlets were presented in quite novel ways as part of the dramas. Most of the dramas were presented with a minimum of props, so that they could be replayed in the barest classrooms. Some were recorded and reproduced as radio programs.

It was early known that the best and most appropriate dramas were to be presented to real "Mrs. Joneses," provided the opportunity arose. This opportunity came in the form of a parent-teacher meeting in an adjoining county housing-project school. The results were that requests were made for

a return of the dramas, not only to that school, but to an adjoining well-baby clinic and other places. The students in the project all indicated that they would be pleased to replay their dramas for off-campus groups. Throughout, they welcomed each opportunity to replay their rôles. Since most of the participants in the original project will be at the college for two more years, the plan is that they be organized into supporting teams for the college community-mental-health program. The hope is that some students, such as the music majors, may be able to present their programs and conduct discussions with a minimum of supervision. The plan also is that these students will become a foundation group for some campus organization concerned with mental health.

The values of the project seem to lie in its being both a pleasant and apparently a somewhat therapeutic experience for the participants, as well as a means by which adolescents can have an active part in positive community-mental-health programs. The reactions of student participants have been recorded. They suggest that the values for the participants may be even greater than for the observers. As the dramas are replayed in communities, however, the plan is to study audience reactions also.

Some of the values for the adolescent participants themselves seem to have been the following:

1. One of the most important values, realized or unrealized, for participants was expressed by one of the students: "Participating in our skit gave me the opportunity to put myself in the place of a parent and in that way be able to understand and sympathize with the problems facing children and adolescents." Another stated: "In participating in the skit, I was able to put myself in the place of persons I portrayed . . . and learn a great deal from this"; another: "As adolescents, we can understand the child's point of view, and as future parents and teachers, we can understand both viewpoints, and observe practical solutions." Both participating in and observing the skits, many students felt to be a valuable educational experience.

2. A second value seemed to be the "preparation-for-vocation" aspect. Students played psychiatrists, social workers, teachers, business men making requests for community services, and the like. They dressed to fit the rôles. They played

parents who were ridiculed quite severely by class-audience reactions for inadequate ways of working out child-parent relationships and who were applauded for better methods. One student stated: "It gives us practice in facing an audience—which we need since we are future teachers—as well as in solving some of the problems which may confront us."

3. For the students who actually presented their dramas to real "Mrs. Joneses," the benefit of audience reactions seemed to have been quite outstanding. Several students recorded a feeling of responsibility for demonstrating to adults psychologically acceptable modes of child-and-adolescent-adult interaction. After her trip to the parent-teacher meeting, one girl wrote: "I noted many of the sayings of the audience which proved that such work as this can prove very helpful. Now I see that we as a group should do more to inform members of our race who do not seem to know about this." After the same parent-teacher meeting, another student rushed to the instructor in great excitement, stating that in one skit, in which the stage had been divided to show the "acceptable" and the "less acceptable" methods of working through such problems as, for example, the arrival of the new baby with the older sibling and behavior at meals and at bedtime, one woman in the audience had applauded the "less acceptable" methods, telling the mother in the drama to whip the child more!

4. Many students seemed to find one major benefit of the project in the group experience. One commented, "It has been a pleasant learning experience . . . that will remain in my memory for years to come." Another wrote later, "It was a growing process, beyond any doubt, in the field of psychology." Others, as the students majoring in music, liked the experience of being able to work in a group and directly relate their major study to the course. The students interested in radio likewise enjoyed working the skit into a technical radio production.

As a community-service teaching device, the value of the skit is rapidly becoming recognized. Printed skits on several mental-health topics now may be secured. It seems, however, that there may be additional values in the development of skits like those described in this project, which meet local needs. Many of the skits in this project had to do with problems of the immediate community and group. Many were extremely

humorous in their "local color." As the director of the college nursery school said after seeing some of the skits, "I laughed until I cried." After one performance, one of the school janitors spontaneously came to say how much he had enjoyed the dramas, as well as how much he had learned from witnessing them. Some of the dramas indicated local professional sources of help. Many of the skits were designed for local radio presentation.

As to further use of this technique, one question that arises, as might be expected, is whether more emphasis should be placed on the technique as a therapeutic agent or as a community teaching device. According to one's decisions as to the direction of emphasis, further developments will proceed.

One criticism by some of the students was that they could have learned more had a greater variety of topics been dramatized. Some suggested that the instructor should have assigned topics. It looks as if this procedure might have increased the variety of themes, and made the technique more educational for the audiences, but perhaps decreased some of the cathartic value of the acting out of themes of the group's own selection. A compromise might be that a variety of topics be presented to classes and the students told to choose from these or others, instead of being left to choose topics in any way that they please. This might be especially desirable if the technique is introduced early in the course.

For more widespread community presentations, there is little doubt that many of the dramas could be improved through further refinements especially of their second scenes, which usually demonstrated the psychologically more acceptable methods of meeting the situations presented. The first scenes of the dramas, in which the interactions were of the psychologically less acceptable nature, by contrast were too often played all too convincingly. A second suggestion, offered by students, was that groups of dramas relevant to the same topic be presented together and followed by discussions of that topic. The discussion method, whether in class or community, should be employed with an adequately trained person in charge.

Another suggestion for further use of the technique with college classes is that the students themselves be given an opportunity to discuss their own and their audiences' reac-

tions after both class and off-campus presentations. Excellent questions were raised even by students who had not witnessed the off-campus presentations. The students who had participated in the off-campus demonstrations in turn seemed to derive excellent prestige values through being asked and attempting to answer these questions.

This kind of technique might be conducted most ideally in a college arrangement in which there was a one-semester course in child and adolescent psychology, followed by a second-semester "action research" course for interested students from the preceding course. In the research course, students would conduct this kind of community project, as well as exploring more intensively topics of their own and of local interest. Requests for this kind of course already have been made to the instructor. This arrangement also might better satisfy the students who prefer a greater range and more intensive exploration of topics such as they would have in classical classroom procedures.

Outside the college classroom, the technique of using skits designed to fit local situations and enacted by interested adolescent groups still should prove a good method of promoting adolescent participation in positive mental-health programs. This use, however, probably would lack some of the cathartic values of the technique as it was utilized in this project. It still should give the adolescent participants, however, a pleasant means of participating in mental-health programs. Adolescent club groups might work out these programs for groups of adults other than their own parents or immediate supervisors. The whole purpose of the dramas should be explained carefully to the adolescents, and if possible, be preceded by discussions on adult-adolescent or adult-child relationships which would emphasize the need for each to try to understand the other, the newness of the concepts for parents, and the possible values of the skits both for participants and for audiences.

THE PSYCHODYNAMICS OF THE TRIAD, ALCOHOLISM, GAMBLING, AND SUPERSTITION *

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THERE is more than a suggestion of chicanery in the title of this contribution. For the offer to expound the common denominator of three distinctive categories must in all good sense carry the implication that each of the separate categories is sufficiently well known to permit of comparison and abstraction. This, however, is most definitely not the case with any of the three psychopathies here conjointed—alcoholism, gambling, and superstition. On the contrary, each of them is something of a moot issue, fringed with a fray of divergent and contradictory observations, theories, and arguments. How, then, are these moot issues to be encompassed within a single exposition, and what am I to plead to the indictment that the title is more smart than valid?

Two arguments I would submit: one is pragmatical, deriving from clinical experiences, and the other is theoretical and is drawn from historical experience. Let me deal with the second argument first. It is an historical fact that certain distinctive pathologies which troubled and puzzled physicians over long periods of time—and which they could not comprehend separately—became meaningful and understandable when studied in the perspective of a common etiology. You will surely recall how disparate and confusing were the pathological entities—phthisis, consumption, scrofula, Pott's disease, and lupus—until the time when Virchow propounded and demonstrated the *unity of the tubercle.* Even more remarkable, and more immediate to our own issue, is the "order brought out of chaos" by the comprehension of the common etiology underlying the wide variety of disturbances

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that include scurvy, pellagra, beriberi, polyneuritis, the Korsakoff syndrome, cirrhotic affections of the liver, night blindness, and a host of other conditions, little understood in the past, but now known to be due to nutritional and metabolic deficiencies.

The moral of this historically validated generalization is that entities that are relatively incomprehensible singly may at times be understood when conjoined. That is the warrant I advance for my attempt to treat the triad—alcoholism, gambling, and superstition. I believe they can be better comprehended in the light of their common psychodynamics than when contemplated singly. Of course, as is nearly always the case, this conviction was not derived from a study of historical precedents and principles, but rather from immediate experience. The historical antecedent only serves to inspire confidence in and to impart validity to the particular experience. It ties it in, so to say, with common knowledge.

The pragmatic experience, which, as you will recall, is my second argument, involved the contemporaneous exposure to three patients—a periodic alcoholic, a prostitute, and a gambler. It was while working with this distinguished triad of patients that I was impressed by the common denominators of their disparate psychopathies. A few words first about the patients.

The alcoholic was a man fifty years of age, bearing the name of a distinguished family, the successful head of a large and important industry, married, and the father of several sons. He was a periodic alcoholic, whose drinking bouts were associated with fugues and radical alterations in personality, recessive in character and characterized by behavior completely foreign and repugnant to him in his non-drinking states.

The prostitute—or perhaps I had better refer to her as the ex-prostitute, for she had abandoned that oldest among professions some three or four years before coming for treatment—was a handsome, well-constituted, and physically sound female thirty years of age. She had been born in a capital city of the Midwest, the daughter of Polish-Jewish immigrant parents. Despite her lack of formal education, and

her fifteen years of Magdalene existence, she proved to be an intelligent, informed, and capable person. At the time she came under treatment she was successfully administering a cosmetic business. Her complaint—that is, the symptom that specifically caused her to seek psychiatric help—was a vague dread of some unknown, unspecified disaster that hung over her and impeded, or at least retarded, her "advance in life." She is the "superstition exemplar" of my triad.

The third patient was the gambler. His complaint did not center about his gambling. He rather accepted gambling as a normal and even desirable component of his living pattern—which, I might add, was enormously complicated. His complaint was of a mild and, as it proved, a transient sense of depersonalization. It was associated with and had been precipitated by the development of a psychotic reaction in his older brother. My patient introjected his sick brother.

The patient was forty years of age, a Jew, almost completely illiterate, married, and the father of two children. He was the successful manufacturer of an apparel commodity and employed a goodly number of workers. He had built up his business from "scratch," and had managed it successfully for many years. He was shrewd and intelligent. He gambled consistently, and had gambled ever since he was twelve years of age. He was, as I have already indicated, a man of substantial wealth. He did not gamble to gain money. Nor did he lose much, in the scale of his wealth and income. He gambled, as he phrased it, because he *had* to gamble; it temporarily relieved him of some kind of tension, the nature of which he did not understand and could not describe.

There seemed to be but few social or psychological factors common to this motley triad of patients—the well-born, wealthy, socially prominent alcoholic; the robust, keen, self-assured ex-prostitute; and the spare, fine-limbed, sharp-witted gambler, whose odd, perpetual, ingratiating smile mirrored his miserable youth in Poland, where he had been apprenticed to a shoemaker at the age of seven; where in the eruptions of the first World War, dodging the searing menace of German invaders, Polish anti-Semites, Red revolutionists, and white counter-revolutionists, he had wandered

with his mother on the byways of the Polish countryside, a mendicant, and a thief by necessity. There seemed to be but few factors common to this triad of patients—at first. But as I came to know more and more of their life histories and could see more clearly and deeply into the dynamics of their psychopathies, I began to perceive in what respects they were akin—what, indeed, was common between them.

This I will propound now, leaving the justification of my proposition to the end. These were three constitutionally able individuals, each successful and effective in an appreciable segment of the totality of their life functions. Yet each of them suffered some crippling personality deficiency that robbed them of the full fruits of their endowments and denied them ultimate effectiveness and happiness. The question I posed amounted to this: Is there a common characteristic in the personality deficiencies suffered by these three, and if so, how is it to be designated, and what may be its derivations or etiologies?

As I brooded upon this issue, it became clear that what was common to these defective personality structures was that they retained within their psychic economy certain atavistic components that impeded their effective operation, something that, like the bronchial clefts, is proper to an early developmental stage, but that should have been outgrown in the process of maturation. In some respects and in some segments of their personalities, these individuals had suffered an arrest in development, and thus presented the equivalents in the psychiatric field of the better understood and more easily appreciated developmental deficiencies to be seen in the somatic field. To be more precise and specific, these patients carried into maturity, and incorporated within their adult personalities, emotional and psychological dynamisms and relational configurations that belong to the pre-adolescent and childhood periods.

During these periods the child is normally and in the true sense of the term at the caprice of fortune. During these years, the laws of cause and effect, of initial act and ultimate consequence, are not only nonoperative with regard to the child, but effectively nonexistent for it. The world of actual reality is a later-day comprehension, which, indeed, not every one

attains. In the child's realm, fancy and fortune (or misfortune) *are* the reality. From the first instant when appeasement is brought to the infant, forcefully dislodged from its earthly Garden of Eden, by some ministering female, and for a good many years to follow, what happens to the child is not related to its own efforts. There is, indeed, no correlation between its inner life and its outer experiences. It does not recognize, it has no knowledge of, causality. This does not, as has been amply demonstrated, hamper the acquisition by the child of simple associational patterns of appreciation and response, not unlike conditioned behavior patterns, nor does it deny the child a rich exercise in autistic thinking.

The thinking patterns of the child are syncretistic, that is "wide and comprehensive, but obscure and inaccurate." The child's logic has been aptly described by Piaget as pre-causal in quality and nature. The child does not comprehend causality as the adult does. For the child, causality is largely an extension of arbitrary intention, the fulfilment of the desire or the caprice of potent agents, human or otherwise.

The behavior of the alcoholic, the superstitious, and the gambler seems to me to be explicable on the assumption that they have retained within their personality structures, and within their psychic mechanisms, the early pre-causal patterns of comprehending, and dealing with, reality and experience. The gambler behaves as if he were still a child to whom gifts may come by mere solicitation, or by teasing for them, as indeed *is* the case in the child's experience. The superstitious individual still labors under the burden of that capriciousness that characterizes the child's realm in which, by inestimable likelihood, disaster may overwhelm or fortune favor. The alcoholic makes use of still another pre-causality pattern, that of the denial of the unacceptable reality. Alcohol is merely the most convenient means for achieving that goal. In the magical, pre-causal realm of the child, the real can in the last resort be deformed at will. To the child nothing is impossible, for in its world nothing obeys causal laws.

The child's world, and the child within its world, are normal and proper—to the child. They are, separately and together, particular instances of well-comprehended reality, and must not be misconstrued out of their normal framework. There

is no pathology inherent in them. The pathology issues from displacement. To revert to an analogy already employed, bronchial clefts are normal in the embryo, but abnormal in the postnatal constitution. Seen thus, the alcoholic, the superstitious, and the gambler are to be viewed, not merely as grown individuals embarrassed by the retention of some childish traits, but rather as sick individuals in whom the retention of pre-adult patterns is a symptom of some serious injury. The crucial matter is not what childish and pre-adolescent patterns they retain, but rather the dynamics of this retention, the why and how of the arrest in development they suffered. This triad of patients do not operate with childish patterns in the world of the child—but with childish patterns in the realm of the adult. The result is not regression, where consistency is still possible, but distortion and disfigurement.

This being a rather brief, and in a sense preliminary, communication, I cannot dilate much, as I hope to on another occasion, upon the dynamics of the arrest in development reflected in this triad. This much, however, I can advance: these patients suffered early and severe deprivations in their affect relations with their parents. They did not experience that rounded cycle of contacts and interpersonal reactions with their parents, most notably with the mother, and also—though this is in the nature of a corollary—with their siblings, that is essential to a healthy development through infancy, childhood, adolescence, and youth. Hence they behave as if harking back to that early period at which they suffered the arresting deprivation. There they appear to be compulsively fixated, and unable to advance.

Let me sketch briefly the early life histories of my three patients. The gambler was born in a little village in Poland, and throughout his youth he was surrounded by poverty and squalor. His father was separated from his mother and lived in a distant village. It was the father's second marriage, and my patient had half-brothers and half-sisters twenty and more years older than himself. He was apprenticed to a shoemaker at the age of seven. And from that age until he married, he had no "home." I mentioned his trying adventures during the years of the first World War and of the revolution that followed.

The ex-prostitute at the age of five lost her mother, probably as the result of an infection supervening on an abortion. The father remarried and attempted to reëstablish a home for his children. He did not succeed in accomplishing this, however, and the children were sent to an orphan asylum. This patient had a great hatred for her father, whom she blamed for the death of her mother, and similarly rejected and blamed her oldest brother.

The alcoholic patient was the son of a self-indulgent, narcissistic mother and a domineering, sadistic father. The earliest memories he had were those of crying bitterly every time his mother left him. Both my patient and his older brother were ceremoniously circumcised—as a punishment for masturbating. Grown of age, having fought in the first World War, having married, and being the father of a young son, my patient happened once to fall ill. Whereupon his father ascribed his illness to sexual overindulgence and offered to finance a vacation trip, provided he would leave his wife at home. Fortunately the father died soon thereafter, or the family might have gone to pot completely.

The three psychopathies herein conjoined have been studied to different extents. Most study has been devoted to alcoholism, least to superstition. It seems proper, then, for me further to expound my thesis, centering my exposition about gambling. Quantitatively, not much has been written on the psychology of gambling, but what is available is of a high order. Edmund Bergler has made both extensive and deep analytic studies of the gambler—whom he quite properly dubs "a misunderstood neurotic." A penetrating and on the whole an acceptable analysis of the psychology of gambling was published a few years ago by Dr. Ralph R. Greenson. Greenson observes: "One would expect to find in the history of neurotic gamblers severe deprivation and/or over-gratification in childhood. This is confirmed by the clinical findings."[1] This is also in harmony with my own observations.

Those who have studied the gambler are in agreement about the principle of his psychological characteristics. Thus he

[1] See "On Gambling," by Ralph R. Greenson. *The American Imago*, Vol. 4, August, 1946. p. 70.

does not gamble to gain money. Money may be the token of his favor, but not the aim of his gambling. The neurotic gambler seldom if ever quits when he has made a "killing." The neurotic gambler stays until he loses, and he seems to have a compulsion to lose. The neurotic gambler appears to know that he cannot win, but acts as if he might. The neurotic gambler behaves as if he were bent on soliciting and teasing Fortune into smiling benignantly upon him and granting him her favors. Neurotic gambling can thus be understood as a compulsive acting out of a plea to the surrogate figures—the mother most likely, but the father also—for a show of favor, for the affirmative response to the questions, "Do you love me?" "Do you approve of me?" "Do you think I am good, and smart, and strong?" It is as if these questions, proper to the child, had for these children, now grown, never been answered adequately in childhood, and thus they remain fixated and incapable of realizing that there are other means for eliciting an appropriate response—the testing of one's worth, for example, in the lists of adult relations.

The gambler is obsessive in his uncertainty—and compulsive in his need to pose the question: "Is Lady Luck with me?" Since a definitive and ultimately satisfactory—that is, reassuring for all time—answer to his query is impossible, the gambler will not "quit" until he is without the means to continue gambling. This will make understandable the gambler's seeming compulsion to lose, for the more he wins, the more means he has wherewith to gamble, and the more intensive becomes the gambling. Release is to be found only in losing.

Bergler and Greenson describe the gambler as one who has regressed to infantile longings for omnipotence. I am rather persuaded to consider him as one who has not successfully egressed out of the child's world of pre-causality. This is equally true of the superstitious and the alcoholic, and for this reason I look upon the triad of alcoholism, gambling, and superstition as developmental deficiencies, and hence with a common psychodynamics.

This is an issue of large import, for it has a bearing on etiology, prophylaxis, and therapy. Should we grant that

this triad does indeed represent the pathology of retained pre-causal patterns of conceptualizing and dealing with reality, then the proper question would be what caused the atavistic retention. Or, more profitably, since physiology is generally more illuminating than pathology, the question might be asked, How does the normal child supplant its pre-causal logic with the logic of causality, and how and where may this process go awry? This would be the protocol for future studies. I am inclined to believe that the primal injury would be found to have taken place in the early affect relations between mother and child, the father playing a secondary rôle.

I am aware that in this presentation I have touched on large issues which deserve more spacious treatment than I could possibly give them here. But on this score I made my apologies at the very start. It is not alcoholism, gambling, or superstition *per se* that fixed my interest, but rather that which is common to them collectively—their common psychodynamics. And in that it is the idea of a psychopathy due to the retention of early pre-adolescent psychological components—within the adult economy—that is outstanding. I have designated this as in the nature of developmental deficiencies or developmental arrests. This type of psychopathology has to my mind not been given the study and attention it deserves.

Because of Freud's emphasis, and that of psychoanalysis in general, we have been much taken up with those forms of psychopathology which are the result of specific traumatic experiences, in which singularly painful, directly injurious happenings had been encountered, and which resulted in neurotic behavior patterns, in ineffective and crippling personality compromises, in the repression of memory, in the splitting of affect from the event or situation with which it was originally associated. Undeniably, Freud's emphasis on the dynamics of these patterns of psychopathology constitutes one of the truly great achievements in the history of psychiatry. No less brilliant and precious was his development of the particular technique of free association which is so effective in the uncovering and in the subsequent correction of these patterns of psychopathology.

Yet there are other sources of psychological morbidity—as

Freud himself affirmed—and one such source I have attempted to delineate in this contribution. The triad—alcoholism, gambling, and superstition—represent conditions notoriously resistant to therapy. But then it is much easier to reduce a dislocated hip than to grow an acetabular socket where one has failed to develop.

VOLUNTEER WORK IN A STATE HOSPITAL BY COLLEGE STUDENTS

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WITH public education in the field of mental hygiene assuming so much importance, it is quite understandable that we should look to the colleges as a fruitful field for this activity. It was in college that Clifford Beers developed the illness that led him to initiate the movement that was to have such far-reaching development. The college student, with his freshened outlook on the values of life, has long been a contributor to movements in which new horizons are explored. Mental hygiene is, therefore, in a position to benefit greatly from participation by college students in activities in this field. This paper is a description of the workings of such a group at the University of Missouri.

The movement had its origin in 1948, under the sponsorship of the Y. M. C. A. and the Y. W. C. A. at the university. As such, it is one of several projects in citizen participation sponsored by these organizations. In these projects the emphasis is on broadening the student's knowledge of community problems. An understanding of the problems of mental health, of the responsibility of the citizen in the operation of the state hospitals, and of the contribution that the volunteer can make would, it was felt, be steps toward the attainment of this goal and also be of great value in fostering valuable attitudes toward mental hygiene in the college student.

As the project is operating at present, the policy of the group is guided by an advisory committee, composed of faculty members, Y. M. C. A. and Y. W. C. A. personnel, and a representative from the coöperating state hospital. It includes the executive secretaries of the Y. M. C. A. and the Y. W. C. A.; representative faculty members from the departments of psychology, sociology, and social work; the psychiatrist of

the student health service; the clinical director of Fulton State Hospital; and student representatives from the Y. M. C. A. and the Y. W. C. A. The functions of this committee are to select the students who are to participate as volunteers, arrange for orientation talks, coördinate the activities of the student volunteers with the hospital program, and in other ways encourage and develop the program.

The selection of students for the volunteer work was necessary for two reasons. First, the number of places available for volunteer workers at Fulton State Hospital is limited by the hospital's physical facilities and the attendants available. Secondly, it was felt that the students themselves should be considered in the light of their own experiences, motivations, and abilities. The selection was made by announcing at the beginning of the school year in various departments that petitions for participation in the project would be considered. The students were required to complete a form in which name, age, sex, class, and major field were asked. Specific abilities in various occupational, handicraft, hobby, art, and sport activities were also asked. After this the student could mention any experiences that he had had in working with organized groups. Lastly he was asked to state his reasons for wishing to take part in this particular project.

In considering the applications, the committee gave preference to the older students, particularly if they were upperclassmen. It was not considered especially advantageous for the student to be majoring in fields related to mental health, such as psychology or social work. Instead, it was felt that there were many advantages in getting students from a variety of fields. For instance, the long-range value of interesting students of journalism, education, or law in the problems of mental health are inestimable. Another criterion for acceptance was some experience in working with people in groups—*e.g.*, as counselor in a summer camp, as leader in a settlement house, or as a scout leader.

In the student's statement of reason for wanting to participate in this volunteer work, it was considered important that he should not intend the project as an opportunity in practicing social work or psychological testing. Instead, the nonvocational nature of participation was considered of much value in this statement. Of course any hint of gross emotional

disturbance would be an important factor. Fortunately this has not been a problem as yet.

After the students are selected, a meeting is held. The first part of it is devoted to organizing the group and assigning the individuals to their tasks. After this an orientation lecture is given. In this the history of society's attitude toward the mentally ill is briefly traced. The great movements in America for helping the mentally ill are emphasized. Then a résumé is given of the types of treatment used in psychiatric hospitals, with an attempt to give the student volunteer some perspective on the rôle his work will play in this. Stress is laid upon the importance of interpersonal experiences and attitudes in treatment. All in all, an attempt is made to stimulate the student's interest in the project as a responsible person making a contribution to one of mankind's more serious problems. Attitudes of morbid curiosity and therapeutic overzealousness are curbed as much as possible.

Volunteer work occurs once a week throughout the school year—on Saturday afternoon for two hours. A few students go every week, but most must limit their attendance to once every two weeks, because of limitations of space at the hospital. Fulton State Hospital is located about thirty miles from Columbia, the seat of the University of Missouri, so that arrangements for transportation must be made by the students themselves. It is felt that this is of some advantage, since it places the student in the position of having to make a small sacrifice in order to participate.

At the state hospital, personnel in charge of the occupational- and recreational-therapy programs take immediate charge of the group's activities. Having received a list of the tasks that the students are qualified to undertake, they assign them accordingly. Most of the patients that the students work with have a good prognosis for recovery and discharge from the hospital, making for a more optimistic atmosphere. An attempt is made to maintain a continuity in these interpersonal contacts by assigning the same patients each time to the same students. It is felt that this is the most effective way to utilize the therapeutic benefit of the students' activities.

The volunteers spend their first hour at various aspects of occupational and recreational therapy. Finger-painting,

rug-weaving, knitting, clay-modeling, and creative writing are examples of the former. In recreational therapy, volleyball, croquet, softball, and other group games are played. For a small group, there is a music hour consisting of record-playing followed by discussions of the record played. The second hour is devoted to dancing, a band made up of patients furnishing the music. Informality and sociability are encouraged during this period by the members of the group.

At the end of the two-hour period, the students assemble with the clinical director for a discussion of various important aspects of dealing with patients. A presentation of a case history usually follows, with an explanation of the meaning of symptoms and behavior, prognosis, and type of treatment. The students are invited to ask questions, to comment on any observations of their own, and to bring up any problems they have encountered in their contacts with patients. It is felt that in this way any unhealthy involvements with patients can be detected and corrected.

This experience has been a very profitable one for every one concerned. The state hospital, with its overworked staff, is very receptive to the arrangement. Without the help of the student volunteers, the effectiveness of their program of rehabilitation would be seriously reduced. The Y. M. C. A. and the Y. W. C. A. have found this project to be one of the most popular that they have sponsored. The enthusiasm of the students for this type of work has been gratifying to the leaders of these two organizations, for it exemplifies the type of community participation and citizen responsibility that they are sponsoring.

From the standpoint of the individual students, the opportunity for social growth has been of prime importance. The feeling of community participation that they acquire has been an encouraging experience to them. On the practical side, the stimulation of the student's interest in fields directly related to mental health has been encouraging. Several students have decided on occupational or recreational therapy as a career as a direct result of their experience.

Another benefit from the project that should be mentioned is the stimulating effect it has had on the rest of the community. Other volunteer groups have been formed and have expanded

as the work of this group of college students has become known through newspaper articles and in other ways.

And of greatest importance from the point of view of mental hygiene are the good will, the interest, and the feeling of personal responsibility that are being stimulated in this group of young people. Destined as they are to become leaders in community life through their positions as educators, lawyers, journalists, social workers, and so on, their ultimate value to the mental-hygiene movement as a whole can only be estimated. Such a working relationship between our colleges and universities and the state-hospital system should be encouraged everywhere as a major contribution to our mental-health program.

MULTIDISCIPLINED EFFORT IN TREATMENT SERVICES*

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IF we look about us, we see on every side the search for some means of coming together, of better understanding of one another. East vs. West, nation vs. nation, group vs. group, all tell the story of this seeking for a way out of the morass of misunderstanding and strife that surrounds us. The physicists, chemists, and theorists have proved, in the production of the atom bomb, how effective teamwork can be, even though the results are somewhat dire. If teamwork can be so effective where destruction is concerned, it could—and if we are to survive, it must—be equally so in constructive living. The number-one problem facing us is learning how to work together.

This quest is uppermost in the minds of many to-day. We find the social scientists trying to effect some change in the culture patterns of the world and the individual's adjustment to them. But must we leave it entirely to the broad fields of social study to figure out how man can get along with man? Why not see how much we can do within our own communities and our hospitals? Surely we must solve the problems of interdependence in our day-to-day living and working if there is to be any hope of broader solutions or broader progress.

I shall attempt in this paper to discuss the small group concerned with treatment; to show how its members relate to one another and to the broader community, how important communication is; and to mention a few of the problems that must be solved if we are to arrive at a real integration of service.

Treatment, in its broadest definition, means the care of the sick. Its purpose is to help the patient attain and maintain the highest level of health. Before treatment can be undertaken, it is essential that the illness be understood. Increasing

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integration of psychiatric concepts with medical theory has brought a growing belief that treatment is more effective if social and emotional factors are incorporated into the total treatment program.

The Joint Committee of the Association of Medical Colleges and the American Association of Medical Social Workers has defined illness as having three major features—physical, emotional, and social. The committee has gone on to say that "these are so intimately interwoven in the pattern of disease that they must be considered together, rather than as separate entities."[1] To understand the patient is to see him in relation to his family, to his community, and to society in general. That means a broad appreciation of how the individual functions amid the forces that surround him. What are the mores of his ethnic or religious group? How do those mores affect attitudes toward illness, treatment, disability, and death? What effect is the illness having on the patient's adjustment to this milieu? How does his family react to the illness? What assets are there in the patient, his family, and his community to help him fight illness and reach the maximum level of recovery?

When illness is considered in this way, it becomes apparent that there is much more involved in the care of the sick than diagnosis. Arthritis of the hands, active pulmonary tuberculosis, or a mental illness of some kind, to mention but three obvious examples, may mean the unemployment of the family breadwinner, loss of his prestige, with all its emotional connotations, added problems and responsibilities for his wife, privations for his children, and expense for the community.

If we accept this concept of illness, it becomes apparent that if treatment is to be effective, we need the skill and knowledge of more than one discipline. Although the training and contribution of each is peculiar to the particular discipline, there are certain basic principles that serve as guideposts to those on the team. Ethel Ginsburg has pointed out that treatment must be patient-centered if the clinic team is to survive.[2] That

[1] See *Widening Horizons in Medical Education; A Study of the Teaching of Social and Environmental Factors in Medicine.* (Report of the Joint Committee of the Association of Medical Colleges and the American Association of Medical Social Workers.) New York: The Commonwealth Fund, 1948. p. 5.

[2] See "Psychiatric Social Work," by Ethel Ginsburg, in *Orthopsychiatry 1923–1948.* New York: The American Orthopsychiatric Association, 1948.

means that all disciplines have the same central objective—*i.e.*, the care of the whole patient. That care is directed by the doctor, who takes responsibility for diagnosis and treatment planning. Treatment, if it is to succeed, requires the coöperation of the patient, based on his understanding, acceptance, and participation. Treatment is a continuous, progressive, and consistent effort, not a thing of fits and starts. Each member of the team should be able to discern feelings. Each should be aware of his own attitudes and reactions and be able, where necessary, to modify them, because of their effect on the patient. Due allowance should be made for the fact that one or another of the team may, at certain times, be more active in the case, depending on the immediate needs of the patient.

Putting these principles into practice becomes possible when certain factors are present. The best integration comes from the administrative level, when the purposes of and need for each discipline are understood and accepted by the chief of staff and his assistants. Integration is also dependent upon clarity of thinking by the disciplines themselves about their respective rôles, upon the ability to interpret these rôles to one another, and upon the freedom of movement that they achieve within their own areas of function. Elizabeth Rice has expressed it thus: "The focus and tempo are geared to the total plan for the patient in such a way that they contribute to the whole,"[1] "the whole" meaning not just the diagnosis, but the physical, social, and emotional factors that contribute to or are affected by the illness. For the present I should like to discuss the treatment services offered by the hospital. It should be remembered that treatment goes on beyond the date of discharge and beyond the hospital grounds and frequently is most lasting when it involves the resources of the community.

In order to illustrate how the many disciplines coöperate in their treatment services to clients, let us follow the progress of Joe Brown from the time he comes to hospital. The material offered here for your consideration is based on actual experience at the Toronto Psychiatric Hospital, but I hope

[1] See "Generic and Specific in Medical Social Work," by Elizabeth P. Rice. *Journal of Social Casework*, Vol. 30, April, 1949. p. 131.

that there will be in it many points pertinent to the experience of other centers.

Mr. Brown comes to the hospital on the recommendation of his family or clinic physician. He is greeted by the doctor on intake duty and taken to the ward, where he meets the nursing supervisor and is helped to settle in. It is at the point of arrival that patients and their relatives feel most acutely anxious and welcome an opportunity to talk with some one who represents a link with the world in which they live from day to day. It is at this point that the social worker has her first contact with the case. The reception interview is carried out in two ways. When relatives accompany the patient to the hospital, they are seen then or as soon after admission as possible (in cases in which admission took place during a time when a social worker was not on duty). The patient is seen soon after arrival.

Of what value is the intake interview to relatives? It gives them an opportunity to express their feelings about hospitalization, to ask questions about hospital procedure, and to know that they can, if they will, share in the treatment plan. It humanizes the hospital at a critical and often traumatic point in their lives.

Of what value is the intake interview to the patient? It gives him an opportunity to express his feelings about coming to the hospital and his fear of what may lie ahead for him; he can ask questions about treatment procedures and why they are undertaken; he feels that through the social worker he maintains connections with his familiar surroundings because she is in touch with his family, with interested friends, or with community agencies.

Of what value is the intake interview to the hospital? The interview with relatives gives us an opportunity to assess their feelings about the illness, and what it represents to them. Has it meant the loss of financial security, or do they see it as a thing to be ashamed of and hidden from relatives and neighbors alike? Either way, what is the effect of their feelings on the patient? Is he rejected, does he meet ambivalence, or is he apt to be overprotected? Out of this understanding of relatives' attitudes, we gain an impression of existing problems and of the extent to which the relatives can participate in the treatment. The intake interviews with

patients give us an opportunity to understand them from the point of view of their ability to coöperate with hospital procedures and to assess our own rôle with them in relation to the treatment plan.

The intake interview represents one of our most valuable tools in the care of the sick. The interview is written up and placed in the hospital record within twenty-four hours, and thus is available to the others concerned with the patients' treatment. It does not follow that every intake interview is the beginning of the social-service contact. It does, however, cut down the risk of late referring. The time at which a case is referred is important if case-work is to be properly coördinated with the other services, and it is one of the responsibilities of the social-service department to help the other departments understand the value of proper timing. The patient needs time to become acquainted with the worker and to plan with her in such a way that his own anxiety about change will be reduced.

Mr. Brown's admission is followed by an intensive work-up, such as history-taking, laboratory tests, X-rays, psychology tests, and other procedures, designed to help us diagnose the illness and plot our course of treatment. Since the patient's progress in treatment depends to a large extent on his ability to accept the plan and participate in it, he often needs help in seeing that it is designed to assist him. This statement is applicable both in general and in psychiatric settings. Electroconvulsive therapy spells terror for some patients; deep X-ray radiation does the same for others. The ability to recognize these feelings, to deal directly with them, or to suggest to the patient that he discuss them with the member of the team most concerned, helps to facilitate treatment.

The doctor carries the responsibility for treatment and planning with the other disciplines. Much of their work is dependent on his opinions of the patient's condition—his fitness to undertake occupational therapy or to begin planning for discharge. The doctor is the one to decide whether the patient has the physical stamina to be employed in heavy work or the emotional endurance to withstand pressure on the job.

The nurse is the person who is with the patient most. She creates the ward atmosphere. She is in a position to build confidence in the hospital and the personnel. She serves as a

link between the patient and the treatment team. Whether she be in a general or in a psychiatric hospital, she works with the others on the team, but within her own area of responsibility. She should be brought into the total plan for the patient, so that her efforts may be directed toward making the plan work. Failure to do this may mean serious problems of ward management for her. There are many similarities between general nursing and psychiatric nursing. The delirious patient or the small child on the pediatric service makes demands on a nurse's judgment and foresight similar to those made by the mentally ill. If she is sensitive to moods and feelings, she can, through capable handling, enable the patient to be comfortable and so make maximum use of treatment.

The social worker starts where Mr. Brown is—in the hospital—and discusses with him problems related to the hospital. The social worker is there to enable him to use the services of the hospital from the time that he comes in until he is discharged. She is careful to focus on the external factors of illness and the patient's emotional responses to them, referring him to the doctor for any discussion of the illness *per se* or the treatment. Trained as she is to observe and to evaluate social data, she makes a worth-while contribution to the whole by relating to the medical situation her knowledge of the environment and of the patient's feelings about it. Her most effective work is done when she has an opportunity to share information and to coördinate her work with the doctor's.

As the patient progresses toward recovery, more environmental factors come into the discussion, thus paving the way for post-discharge planning. Simultaneously the social worker may, with Mr. Brown's knowledge and consent, be seeing his relatives, in order to help them understand how they may best help him. If there is a community agency interested in him and his family, the social worker in the hospital setting may be the liaison between the doctor and the agency.

One of the most important people connected with our patient's care is the occupational therapist. Her rôle has been defined as "the scientific adaptation of activity in the treatment of specific physical and mental disabilities." How does she approach this task? By reading his history and having discussions with the doctor, the social worker, and others,

the therapist brings to her tasks a knowledge of the patient's illness, the needs it has created in him, and the potentialities for the future. She brings a knowledge of his background, his work experience, and his future plans. She brings an understanding of the value of certain activities and the danger of others. As she works with him, she tries to know him better and her observation of him in a group furnishes valuable leads to the others on the team. Her work frequently carries over into the post-discharge era, either through the hospital occupational-therapy outdoor service or the community occupational-therapy center. In this way she helps him through what is often a trying convalescent period.

The understanding of Mr. Brown's problems and potentials for future adjustment are deepened by the work of the psychologist, whose function it is to appraise and aid in diagnosis. The investigatory techniques used bring out latent abilities, and these are kept in mind when planning begins. Often the discovery of these abilities give the patient reassurance and confidence and a consequently greater ability to coöperate in treatment. If Mr. Brown is unskilled, or wishes a change of employment, the trained psychologist may undertake to explore with him job possibilities suited to his talents. This calls for careful integration with the doctor and the social worker and a sharp definition of the area of discussion to be undertaken by the psychologist.

If the patient is to make use of all the services in the hospital, it is important that he build up his strength, and the dietitian is the one to help him do so. A special diet or a tempting snack will often create variation and stimulate his interest in food. This is important for all patients, but particularly so in long-term cases. Suppose Mr. Brown has a back injury and is encased in a body cast and obliged to remain practically immobile for months or years. He is very apt to experience a strain on already heavily taxed emotions that might threaten his ability to coöperate in treatment. Or suppose he has diabetes. With the help of the dietitian, he can learn the value of a controlled diet and not only benefit from it while in hospital, but take his new-found knowledge home with him. Her appreciation of the importance of diet as related to illness enables the dietitian to be of great help in

the care of patients whose well-being or even recovery is largely dependent on what they eat.

I have touched upon only the most obvious of the disciplines that have to do with treatment. I could go on to mention others—the speech therapist, the physiotherapist, and all the other specialists who contribute to the well-being and recovery of the patient. Just a word here about the importance of the hospital personnel who come into contact with Mr. Brown, though not so intimately connected with his treatment as the doctor, the nurse, or others. I refer to the laboratory technicians, the orderly, or the clerks whom Mr. Brown may encounter. If they see themselves as part of a treatment center, and if they have sensitivity to the feelings of others, they can help to make patients comfortable in the hospital setting.

As the day approaches for Mr. Brown to leave the hospital, he may experience a natural anxiety about his ability to return to the responsibilities and competitions of life in the community. He will be helped with this if he is given an opportunity to plan for discharge. Timing is important here, too. The knowledge that his doctor's interest will continue, that his social worker plans to see him and his family until they get through the initial adjustment period, that he can continue in occupational therapy if he is not ready for work, or that a community agency will help him and his family until he can become a self-sustaining member of the community, all are factors that combine to make it easier to continue his progress. Timing is equally important in cases in which prognosis is poor, for these patients need careful planning, especially if they are unable to take much responsibility for their own needs. The patient dying of cancer or the deteriorating schizophrenic present real problems for post-discharge care.

In order to work coöperatively, we must share, but how much? It seems to me that the information pertinent to the rôle is the criterion to be followed in sharing. The occupational therapist should know that a patient is suicidal in order to avoid encouraging him in an activity that calls for sharp tools. The employment agency should know that a patient is epileptic so as to avoid putting him to work on machinery. Whether the patient has conflicts about sex, may be of interest,

but is not of great consequence either to therapist or to employment agency.

Because of her knowledge of the patient, his social background, and his feelings about it and what the illness means, the social worker carries much responsibility for helping others on the hospital staff to understand social implications. In order to do this effectively, the department should be well established and considered as much a part of the hospital as the laboratories. It should have capable staff under able leadership, display a high quality of performance, and be regarded as part of the teaching apparatus of the hospital. Such teaching is best done when the social worker can express herself clearly and simply and feels secure enough to do so without becoming defensive or apologetic if some of her ideas are challenged. The social worker who carries such responsibility should be flexible in her dealings with people, able to appreciate their endeavors and to interpret her own part in the treatment program. Clarity about objectives is a fine thing, but translating objectives into action is better, and it is this that calls forth the skills of the team members.

Integration based on understanding of social implications and of the rôles of others in treatment is important in order that we may serve the patient well. Before discussing possible methods of integration, I should like to mention some of the factors necessary to the achievement of it.

First of all, let us take a look at ourselves. How well are we acquainted with the real person as distinguished from the ideal we have of ourselves? We need to watch for our blind spots because our own feelings can color our thinking and our reactions to situations and get in our way to such an extent that we cannot work with patients or other personnel.

Secondly, what about the other fellow? How much do we know about his attitudes and feelings and working methods and our own responses to them? Only to the extent that we understand them do we reach a satisfactory working relationship.

If we are engaged in certain professional areas, we should have some awareness of why, what it is we hope to achieve for ourselves as well as for others by being there, and the extent to which we can control our activity and share with others in the interests of the common good.

It is not enough, however, to know our own and the next man's personality make-up and methods of working. It is equally important to understand one another's functions. In order to do so, we need to comprehend our own. It is one thing to know how to do a thing, but sometimes it is another matter to know why we do it. Unless we know why we are doing our job, we are in grave danger of overlapping and getting it mixed up with some one else's. When we know what we are doing and why, we are much more apt to be able to talk about it and to give an illuminating exposition of our rôle. It is only when we can interpret and keep our lines uncrossed that we can give the best service to our clients.

If we are to achieve integration of service, we should start at the top—at the administrative level. If the department heads are clear as to how their respective sections operate, they will be able to teach the concepts of teamwork to newcomers on the staff and trainees, and so facilitate integration at staff level. Hopefully, in that way, coöperation between departments would be improved.

Conferences can be useful tools in achieving integration. These range all the way from meetings between doctors and others for the purpose of planning treatment, to the formal case presentation which all staff members attend.

The most effective teaching is considered to be done in day-by-day contacts among the individuals concerned with treatment. Frequently function is discussed, integration achieved, and social implications are taught.

A good example of this was seen recently when confusion arose over the rôle of the social worker in a certain case. The patient was a man in his late thirties, married to a woman four years his senior. He still had close ties with his aunts, who had brought him up. He had suffered an accident in early childhood which had left him quite lame. As a result, he had been sheltered and protected and had grown up to be passive, indecisive, and immature. His wife had never been accepted by his relatives and had a good deal of feeling about her position in the family group, especially since their rejection repeated the experience of her early life.

For three years prior to hospitalization and particularly since the birth of a son, there had been, on the part of the patient, a lessening interest in his wife, the baby, and things

in general. By the time he was admitted, she had real anxiety about the situation. Good rapport was established with the social worker, and the wife was able to express her feelings about things and gave evidence of being able to make plans if given time to sort out her own emotions and attitudes.

After two interviews with the wife, the social worker learned from her that the doctor, after interviewing her to obtain a history, had requested that she see him regularly. She was confused by the dual contact and was on the verge of withdrawing altogether. At that point we sat down with the doctor to plan a little, as it was apparent that we needed to tidy up our thinking about who was doing what and why.

The doctor did not see his contact with the wife as a psychotherapeutic one, and said that he had had no intention of undertaking treatment, but he could not explain how he did see his rôle with her. At the same time he could not see how the social worker could consider it her job to handle these problems. As we discussed our function, he came to see that the wife's problems were related to the patient and his illness and his feelings about the environment and that unless she could gain some insight into their relationship, the patient would go back to the same intolerable situation. The discussion of the home gave the worker an opportunity to bring in some point about the wife's background which bore out the theory that her marriage had only continued her early deprivations and caused her to react in her usual aggressive way. The doctor began to appreciate that he had been seeing the wife and the relatives in an effort to understand the illness, because the patient had, until then, refused to discuss his problems. The doctor then realized that, by focusing his attention on the patient and trying to get at his problems, he would be able to help the worker in her task with the wife and the two could thus go along side by side.

Conferences with community agencies are another way of teaching social implications and integrating the work of the hospital and the community. A conference to plan for ten-year-old Mary brought this out. Mary's father was in jail and her mother was living with another man. As a result, the child was, in many ways, left to her own devices. No one had evidence of neglect, but every one felt that it was there and was reflected in Mary's behavior. Mary became known to

a children's agency, which sought psychiatric consultation. After careful consideration, this was followed by admission to hospital. As the agency did not have wardship, planning hinged on the mother's acceptance of whatever decisions were reached.

The conference was attended by the doctor, the nurse in charge of the ward, and social workers from the hospital and the agency. The suggestion was that Mary be placed in a foster home for two years and the mother forbidden to visit her. It was hoped that during that time Mary would have adjusted to her surroundings. The agency worker brought up some of the problems of the agency that would stand in the way of such a plan. To begin with, foster parents are ordinary people, not trained to handle behavior difficulties and apt to react to them in a normal way, even with the best intentions in the world. Foster homes were hard to find in any case, and the worker felt that it would be next to impossible to find one with parents equipped to deal with Mary's problems. Secondly, Mary was not likely to settle down in a place that she would be sure to consider temporary, and it was unlikely that any one could prevent her mother from visiting if she chose, for in spite of her behavior, she had affection for the child. The combination was likely to result in the loss of the foster home and to start Mary on a long round of short stays in other homes with her behavior becoming increasingly difficult to handle. It was finally concluded that we should endeavor to find institutional placement and try to effect it with the coöperation of Mary and her mother.

The formal case-presentation conference, attended by joint staffs, is an illustration of interpretation, but not necessarily of integration. The doctor presents the history and medical findings and the diagnosis made on the basis of these. The nursing service reports on its experience with the patient on the ward, mentioning the extent to which he is able to coöperate with ward routines and commenting on any deviations of behavior or difficulties he may have with other patients or staff. The psychologist reports on her findings, pointing up the patient's response to tests and the meaning of these responses in terms of his adjustment to hospital, underlying conflicts, and potentials. The occupational therapist reports on the patient's adjustment to and interest in the program,

how he gets along in the group, and discusses his employability. The social worker reports on her experience with the patient, the problems that concern him most and what has been learned from him or his relatives or both regarding the situation.

All these methods serve to bring together representatives of two or more disciplines, and the sharing that is done in such conferences contributes to our understanding of one another's jobs. These methods, however, should not be regarded as blue prints, but rather as rough sketches on which to base our thinking for future developments, for they do not provide the whole answer to the problem.

In conclusion, I should like to mention briefly some of the obstacles that lie in the path of integration. One is the lack of teaching of social implications in the curricula of most disciplines. How well equipped are we to think of the patient in relation to his environment? How much do we really appreciate his feelings or those of his family? How much do we understand the meaning of illness to a community?

As the sign on the highway points out: "Accident is only a word until it happens to you." So it is with illness, be it poliomyelitis, cancer, or schizophrenia. I am not suggesting that the only way to grasp the meaning of something is through identical experience. I am suggesting, however, that training can give us awareness and the ability to use our affect, imagination, and knowledge of other services. Such integration is unlikely to occur in the types of conference I have mentioned because they are primarily an information-getting and giving process, rather than a discussion of why certain things are done. Lack of time is another obstacle. Organized planning between disciplines involves time and often the sacrificing of some other part of the program. Perhaps it would be time saved and service improved if that sacrifice were made.

Another obstacle is the lack of trained personnel to teach and help reduce the confusion of thinking that characterizes most disciplines. As it is highly improbable that we will be able to produce skilled people in sufficient numbers to solve this problem in the near future, it becomes all the more important that we be able to communicate with one another and so share what we do know. The failure to interpret well

is due, at least in part, to the insecurity within us and to the tendency, particularly on the part of new services, to be over-aggressive. The end result is that we threaten more than we help one another and communication breaks down.

Unless we learn to communicate with one another, we will continue to grope. Surely we must communicate in a hospital or a clinic setting where different disciplines come together, for only as we find the ways and means to do so on a small scale is there hope for solutions on a broad scale.

ORGANIZING FOR MENTAL HEALTH IN THE LOCAL COMMUNITY*

SAMUEL WHITMAN
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EVERY one is familiar with Stephens Leacock's description of the man in love who flung himself on a horse and rode off in all directions. The goal of mental health is one that is apt to catapult sincere and intelligent groups of citizens in all directions. To one individual, the all-important and only goal is the improvement and expansion of mental hospitals and facilities for the mentally deficient. Another turns his back on those who have become mentally ill and plunges into a crusade for preventive child-guidance clinics. Still another scorns these measures as merely corrective and turns his efforts to "real prevention" in the form of anticipatory guidance to mothers in well-baby clinics. "Too late," moans another. "These mothers should have been reached when they were in school." "More mental hygiene in the classroom," becomes the popular cry. "But," observes another, "how can you offer mental hygiene in the classroom until teachers develop greater awareness of the problem?"

And what of religion, recreation, public-health and welfare agencies? What about doing something about social problems, such as housing, unemployment, chronic disease, and so on? Many thoughtful citizens, lay and professional, reflect Dr. Temple Burling's observation; "Sometimes our therapeutic efforts seem to me much as if an orthopedist were to develop a method of greatly thickening the skin of a heel of one of his patients instead of removing the nail from his shoe."

It is difficult to deny the validity of any of these points of view. However, the executive who is aware that progress cannot be achieved on all fronts at the same time is faced with the challenge of drawing cohesion out of diffusion, and

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facilitating agreement upon the scope of the program. Because it is close to individual citizens, the local mental-health organization is in a unique position to work intensively toward establishing what Clarence King calls the "firm central cohesive core" which is basic to all community organization.

I plan to limit this paper to a consideration of the following problems in organizing for mental health in the local community: (1) defining the extent of the problem; (2) establishing objectives; (3) relating the local group to state and national programs; and (4) guiding principles and methods of leadership.

Defining the Extent of the Problem.—The importance of clarifying the scope of the program in quantitative, as well as qualitative, terms has been acknowledged by many, but has been generally underestimated in actual practice. To many of our citizens, mental illness is vague and abstract until the problem springs to life in a citation of figures. It is easier to discuss the need for a psychiatric clinic or for expanding the staff of a state hospital than to answer the questions that are being asked by an increasing number of intelligent citizens: How big is this problem? How many persons are there *in our town* who are mentally ill and in what stages of illness are they? National figures regarding the estimated incidence and prevalence of mental illness are available, but these estimates seem remote and are not necessarily viewed as applicable to the local situation. In spite of all the scoffing about statistics (figures don't lie, but liars figure), the attention of the average citizen is arrested by numbers.

Now I am not suggesting that the measurement of the prevalence of mental illness is easily obtained. Our measuring devices are crude and are admitted by the experts to be inadequate. Research to sharpen the necessary tools is urgently needed. But until such sharpening takes place, there is much of value that can be done with available devices.

In this connection, we should note the pioneering work of Lemkau, Tietze, and Cooper in Baltimore, the Tennessee Survey, and recent studies made of Butler and Miami counties in Ohio, under the direction of Dr. Mangus. The results of the Miami County Survey startled the citizens out of their

apathy and shook the old belief that rural areas have fewer cases of emotional disturbance than their urban neighbors. There followed in that county the establishment of its first psychiatric clinic and an intensified educational program.

In Cleveland, the desire for improved psychiatric facilities has been growing steadily, and the demand for additional facts has grown with it. How many need care? What kind of care? Hospitals or out-patient clinics? Who will pay the cost? In what direction should research and preventive activities proceed? To answer these questions we have formulated a tentative plan for a survey involving three steps. First, we plan to approach all our psychiatric units, about twenty in number, where the pressure for treatment is felt most acutely. Figures will be obtained about the number and kind of patients now under treatment. Second, we will try to secure an estimate of the number who are on the waiting lists of these hospitals and clinics. Third, an attempt will be made to secure estimates from health and welfare agencies and schools of the number who would be referred if facilities were available. We do not expect that such a survey will provide all of the facts, nor will it result in miracles. But we believe that it will provide more of the facts that are needed to heighten the conviction and support of interested citizens.

These comments should not be construed to mean that no forward movement is possible without exhaustive surveys. Clinics have sprung into existence, hospital facilities have been improved, mental-health education has been initiated as the result of a community spasm caused by a well-publicized atrocity committed by a mental deviate. Communities do react to emotional conflagrations, but too frequently the result is spotty and piecemeal. Another finger is applied to the dike, but the floods continue to rise higher. In the long run, if we are to do an effective job in stemming the tide, we must devote more energy to securing sharper estimates of the nature and extent of the problem.

Establishing Objectives.—To do nothing until "all the facts are gathered" would be comparable to doing nothing about a client's financial crisis until a complete social and psychiatric diagnosis is obtained. What does a community do before all the facts are gathered? Before attempting to answer this

question, I should like to refer again to the task of selecting objectives and areas of activity. Briefly, there are two pitfalls. One is the kind of thinking that results in a program preoccupied solely with disease, hospitals, and clinics. The other is to accept as a goal any activity intended to make individuals happier. Referring to the broadening and thinning of the program of a certain mental-health organization, a friend dryly observed, "At the rate they are going, they will soon be developing a committee of the local bartenders because of the stories of frustration they absorb over the counter."

I believe it essential for an organized mental-health group to spend the necessary time and effort to achieve free expression of opinion about objectives. Listing objectives may not produce action, but it serves the important purpose of achieving unity of purpose in the group. The problem then emerges of selecting specific areas of activity and listing them in the order of their importance. The question of feasibility or attainability of goals also enters the picture. Choices made will naturally reflect particular needs and pressures of the community and will vary from one area to another.

It may be appropriate at this point to describe the development of some specific activities in the Cleveland area. One of the earlier problems which had provoked considerable concern was the need to improve conditions at Cleveland State Hospital. In fact, our organization was born in the midst of a rather lively exposé of attendants' brutality, overcrowding, and neglect. The newspapers and *Life Magazine* had just punctuated what Albert Deutsch would term "the agitational phase" toward improvement. From the number of phone calls and letters received at the office, it was apparent that this situation presented a logical focal point for action. In the jargon of our trade, we began "at the point where the community was."

Conferences with the superintendent revealed that he was convinced of the interest of health and welfare groups, but that he had had few visits from legislators, civic groups, and business men's organizations. He acknowledged that much interest had been stirred up, but that effective, persistent, and methodical coördination of this interest had not materialized. He offered to open the doors of any part of the hospital to any group seeking to learn at first hand the serious effects of

personnel shortages. We then undertook to encourage groups to take advantage of his offer. During the last few years, hardly a week has passed in which some civic group has not visited the hospital. Legislators, church groups, women's organizations, and P.T.A.'s came and gained a fuller appreciation of the problem through visual aids of a stirring quality.

Added impetus was given to citizen participation when Coca-Cola and the Scripps-Howard Press of Cleveland and Cincinnati sponsored a series of trips to most of the Ohio state hospitals. These trips were taken by a number of clubwomen, representing prominent organizations, and culminated in a joint meeting at which they reported their observations. There is little doubt that this kind of activity is more effective than the perennial and mounful moan, "Not enough of anything!"

A significant result of such visits was the increasing number of volunteers who offered practical and much needed services similar to those performed by the Gray Ladies of the Red Cross. In view of the traditional attitude of professional hospital personnel toward volunteers—an attitude ranging from open rejection to polite tolerance to genuine acceptance—it may be appropriate to mention some of the volunteer activities to which the hospital staff has reacted with enthusiasm: planning of parties and dances for patients; cosmetics and hair re-styling; sponsorship of the sale of patient-made articles in community stores; distribution of books and games; distribution of holiday gifts; playing music. We have found these volunteers to be not only effective interpreters of hospital needs, but a highly motivated core of citizen action.

As we became increasingly aware of the potentials of such service, our organization, in coöperation with the Volunteer Bureau of the Cleveland Welfare Federation, proposed to the superintendent the establishment of a new position—"Coördinator of Volunteer Services." This position, now established and filled, promises to bring hospital and community closer together. Another step of equal importance toward this goal was the superintendent's decision to meet our request to appoint an advisory committee of prominent citizens whose job it would be to take a continuous interest in the hospital, its problems and its needs, to make suggestions

for change, and to recommend appropriate legislative measures. On this committee are lawyers, business men, a physician, housewives, a city councilman, and the city welfare director. As they become more familiar with the aims of the hospital and the bottle necks in the treatment program, the members of the committee will be able to present effective testimony before the finance committees of the state legislature.

A second objective resulted from a number of complaints from social agencies, psychiatrists, lawyers, and the relatives of patients. They criticized the commitment procedure—which necessitated the appearance of patient and family in open court—as being needlessly traumatic. Scattered complaints were crystallized by the formation of a committee of attorneys and psychiatrists to study existing commitment procedures and to make proposals for improvement. Starting with conflicting viewpoints, the committee reached agreement after months of deliberation. The recommendation was made that the law be changed, making possible the admission of mental patients upon the certification of two physicians without resort to any judicial procedure. Coöperation with a similar committee in Dayton strengthened the support for the proposed bill. The Ohio Mental Hygiene Association assisted by stimulating and coördinating a state-wide effort to secure its passage. Witnesses to testify for the bill were not lacking. Committee members who had devoted much time and energy to the problem locally did not need to be coaxed to appear in Columbus to defend their ideas. This calls to mind Dr. George Stevenson's observation that "legislation does not begin in the halls of the state capitol."

A third goal is the expansion and strengthening of clinics and the establishment of psychiatric wards in general hospitals to meet some of the immediate and known pressures. Meetings and informal conferences with our general-hospital officials have encouraged them to move forward in these areas. One of our former board members, the director of a general hospital, has established a mental-hygiene clinic and is planning to open a ward for patients who need hospital care.

A fourth project which we have considered of major importance is the strengthening of the mental-health program of our school system. A committee was organized under the

leadership of a prominent attorney to consider methods of achieving this objective. The committee decided that its aim would be the development of an in-service training program to help teachers develop a deeper awareness of the emotional needs of all children and greater skill in handling day-to-day problems. School authorities were approached and agreed that a psychiatric consultant would be employed. The committee further assisted the school authorities in locating a uniquely qualified psychiatrist to undertake this challenging job.

The fruition of this plan illustrates a significant point. It is noteworthy that a community which formerly concentrated so much attention upon the state mental hospital has gradually come to invest some of its energy in a preventive program. This may be a sign that there is a growing awareness of the increasing responsibility the locality can assume for developing its own resources.

If our limited experience is any indication of a trend, it might be said that communities tend to be stirred initially by the plight of those who are severely ill. Thinking citizens then begin to ask why it has been necessary for some patients to spend as much as fifty years in a mental hospital. With the discovery that much can be done to improve the efficiency of mental hospitals, the next preoccupation is with the question of the prevention of disease through early diagnosis and treatment. Nevertheless, emphasis still tends to be on those who are ill and who need treatment.

Gradually, however, there emerges a fuller appreciation of the need to keep people from becoming ill and to help them stay well. At this point we begin to hope for educational projects grounded in public understanding of the relationship between prevention and treatment. Unfortunately, this concept is appreciated by altogether too few. Apparently the public pulse does not quicken in response to the need for preventive education. The public is naturally more apt to be stirred by an announcement that the mentally ill are still housed in jail. It's exciting to help put out a fire, but it's a nuisance to be careful with burning cigarettes. In the words of Dr. Alan Gregg, "What is immediate and pressing tends to crowd out the ultimately valuable."

Every community is, therefore, faced by the difficult chal-

lenge of making concrete these vital educational goals: (1) exploding popular fallacies about mental illness—both the fallacy of incurability and the fallacy of quick cures; and (2) fostering the application of mental-hygiene principles to everyday living.

In an effort to achieve these goals in our area, we have maintained a lively working interchange with our local newspapers and have featured motion pictures, plays, radio, popular literature, public meetings, and group discussions. We have found it worth while to recognize the importance of proper "packaging" and public-relations aspects in promoting this educational program. At the same time we have found it essential to preserve a balance between packaging and sound content. It is not my purpose to elaborate on the problems of maintaining this balance, but to point out the rather startling underestimation of the public-relations aspect in a field in which public support is practically a condition for success.[1]

In pursuing the educational aims to which I have referred, there are two serious mistakes that a mental-health group can make. One is to assume that it can do the job by itself, independent of other social agencies and institutions in the community. The other is to assume that the responsibility for mental-health education is the exclusive job of the psychiatrist, the psychologist, or the social worker.

A mental-hygiene society can't operate in a vacuum. The local society must be in the main stream of community life; whether supported entirely by memberships or by the Community Chest, it should become part of the fabric of health, welfare, and education in the community. The Cleveland Mental Hygiene Association is a member of the Health Council of the Cleveland Welfare Federation. It has been participating in the work of various committees and councils of the federation, such as those on case-work, health education, alcoholism, adult education, legislation, and occupational planning for the handicapped. We also meet with committees set up by churches, schools, and other community groups. Such participation affords a natural opportunity for interpretation

[1] A noteworthy contribution to the problem of mental-health public relations has been made by Lynn Stratton in a pamphlet entitled *Interpreting Mental Health*, published by The National Committee for Mental Hygiene.

and often gives rise to increasing requests from parent groups, teachers, nurses, clergymen, and recreational leaders. They have come more and more to appreciate the vitality of mental-hygiene concepts and to want help in improving their own skills to enable them to help others more effectively.

At the same time, with the stimulus provided by interesting plays, radio programs, and 16 mm. movies, the demand for educational programs has grown tremendously. This poses an engineering problem. Whereas initially it was possible and appropriate to spend a substantial percentage of our limited staff time in direct educational work, we now find ourselves spending more time in mobilizing community talent to meet the increasing demand and in consultation with groups in helping them arrange sound programs. In this connection it is encouraging to see the growing number of psychiatrists and clinical psychologists who are volunteering time.

It may be pertinent also to mention how warmly family-service agencies and mental-hygiene clinics have responded to our request for social workers to lead discussions in parent education. After eighteen months of experimentation, these group leaders have been called together from time to time for the purpose of sharing experiences, discussing problems that have emerged in group education, and refining educational content and methods. They have considered the nature and dosage of content in a "one-night stand" as distinguished from a series, the recognition and handling of anxiety-ridden questions, the use and misuse of films, and so on. We have felt in all this an encouraging attitude on the part of our local agencies who see this type of education as a possible addition to their case-work function. This attitude in a sense both creates and reflects the sentiments of the Family Service Association of America working with The National Association for Mental Health.

In addition to our work with parents, we have responded to the growing requests from public-health nursing groups for practical help in dealing with the emotional problems they meet while attending to their more tangible duties in the home. Many have been inspired by public-health leaders to be more conscious of their opportunities for giving emotional first aid. Although formal lectures by prominent mental hygienists have

proven stimulating, there is increasing emphasis upon informal meetings in small groups.

I had the opportunity to observe how the interest of a local nursing group was stimulated by a public lecture. In response to the request of the staff, the supervisor made it possible for them to attend a series of four popular mental-hygiene lectures. Hundreds were in the audience. After the series the supervisor shared the reaction of her group with me: "The lectures were enjoyable, but they don't tell us what to do about Mrs. Jones."

After a sounding out of her staff, it was decided to arrange a series of six informal sessions led by an experienced case-worker. Only the staff, numbering about twenty-three, were to attend. Members of the group participated in the selection of course content, thereby insuring attention to the problems arising out of their actual experience.

When the sessions came to a close, the staff still did not have "the" solution to Mrs. Jones's problem, but they were better able to see what could and what could not be done for the patient. Emphasis was upon developing a set of working principles rather than upon a list of magical "do's and don'ts." For the majority, these meetings resulted in a lessening of anxiety about insoluble problems and a greater sense of security on the job. Needless to say, results of this kind are difficult to achieve unless the discussion leader has, in addition to technical information, some awareness of the nurse's orientation as well as a real identification with her problems.

The value of discussion in small groups, under able leadership, applies also to the classroom teacher. The employment of a psychiatric consultant by the Cleveland school system has been mentioned earlier. Although some contact with school authorities over a long period of time was necessary to accomplish this, our organization was at the same time helping groups of teachers to arrange mental-health programs. This provided the necessary impulse from within the school and resulted in a substantial core of teachers who are ready to use the services of the psychiatric consultant. The strategic rôle of the school in helping to develop a generation of children who will not need to fight to settle problems has become a

cliché. To make this important goal a reality, we will have to take it out of the realm of dynamic phraseology and offer the teacher the consultative services that will enable her to do a better job. As a corollary of this view, we have also a responsibility to be vocal with regard to administrative changes in salary scales, as well as in size of classes.

The foregoing illustrations of objectives and activities point inevitably to one of the most significant needs of a mental-hygiene program. I refer to the importance of developing lay and professional leaders in community organization for mental health. The problem of creating increased opportunities for lay leadership as well as "followership" is ever with us. We are, at present, groping our way with an idea that may not be at all unique. A few years ago, our board voted into existence the Council for Mental Hygiene, now composed of delegates of thirty-seven service clubs, churches, and civic organizations. This action was taken as the result of a veritable community spasm caused by the sordid murder of an eight-year-old girl by a psychopathic delinquent. Attention was drawn to the number of mental deviates in town who go about untreated and unsupervised.

Projection of blame on others was the order of the day. Addressing ourselves to the widespread concern, we made an effort to help various groups recognize that it is "we" acting together, and not a mythical "they," who will achieve results. At first a small number of groups responded to our request to send delegates to the council, but this number has increased substantially. Delegates meet monthly, and activity is lively and impressive. It was this group which provided almost all of the Cleveland participants in the Scripps-Howard Coca-Cola project referred to earlier in this paper. Now beginning its third year, the council has demonstrated a possible pattern for community education and for the development of a larger number of informed lay leaders. What seems to be of particular significance is the value that this group has had in helping the mental-health program become a part of the community's natural groups.

On the professional side, we have opened our agency as a student field-work-training center for community organization, in coöperation with the School of Applied Social Sciences

of Western Reserve University. This has been undertaken as an experiment and will be evaluated in the near future.

Relating the Local Group to State and National Programs.—It is generally agreed that, in the final analysis, the quality of international, national, and state programs for mental health—or for world peace, for that matter—rests upon what John Doe in the local community thinks, feels, and does. If John Doe is narrow, complacent, and rigid, he is unwilling and unable to think beyond his immediate needs and frequently does not recognize that his immediate well-being is synonymous with the well-being of state and national programs. If John Doe is just an average citizen, he can be led to see the relationship between poor mental hospitals and the need for him to support a progressive state mental-health program. When the leader exerts an extra bit of energy, the average citizen can be helped to understand why he should support the national program for the solution of problems which the local and state units of government have been unable to solve by themselves, such as increasing the supply of trained personnel and expanding research and clinical and educational services. Probably the most difficult level for the citizen to envisage is the international level. There is little doubt that the local community is in need of help in "tangibilitating" what for too many citizens is an abstraction.

We do not see one level of operation as more or less important than another. We view them all as having unique functions, each dovetailing with the others. I suppose that there will always be fear among humans, even in mental-health organizations, that the international group will dominate the national, which in turn will dominate the state, which in turn will dominate the local. The history of the mental-hygiene movement in the United States should prove reassuring to those who may entertain such fears.

Inter-level coöperation is a two-way process. It goes beyond the national group's representing the states before the Congress and the state's representing the localities in state legislatures. For instance, the locality may report to the state mental-hygiene society the need for 1,000 more state-hospital beds. The state group will make an effort to incorporate this need in the total state program. This, however,

places upon the locality obvious obligations—the provision of financial support and of citizen support for legislative measures. The state group has the obligation of pulse-taking and educating legislative representatives, keeping the localities informed about bottle necks in legislation and how the local groups can contribute to the neutralization or elimination of such bottle necks. The state group may be expected to guide the local community in its efforts to solve its problems and to help coördinate such efforts with other localities in which similar problems exist.

It is axiomatic that the greater the voice that localities have in the determination of state and national policies, the fewer the chances that state and national leaders will be frustrated in their hopes for an enthusiastic response to a proposed measure. To go into greater detail regarding the problems and opportunities of coöperation among the various levels would be beyond the scope of this paper. It goes without saying, however, that we have hardly tapped the potentials for coöperation toward a forward-looking mental-health program.

Guiding Principles and Methods in Leadership.—In this discussion of the various activities and problems involved in a local community's effort to improve its mental-health resources, I have only touched upon the rôle of leadership and method. It may be appropriate at this point to mention just a few of the principles by which we have been guided:

1. Leadership has been consciously indirect rather than direct. The rôle of the professional leader is that of helping community leaders to assume responsibility. His function is to facilitate rather than to assume total responsibility.

2. Communities need help in defining the extent and scope of the program. Horizons and vision may be limitless, but tangible progress can be obtained only by breaking down the problem into discernible and well-defined areas of activity. These activities, however, are not held too rigidly, but are subject to modification in accordance with the rise and fall of community interest and concern.

3. It is relatively simple to initiate activity, particularly if the program has a broad sweep; caution is indicated lest more activities be initiated than can be adequately supervised. Once under motion, appropriate doses of encouragement and

direction must be given to committees to help them achieve continuity and to think of next steps.

4. To play an effective rôle, mental health must become a part of the health and welfare and educational services in the community.

5. Our objectives can be carried out only through people and not through paper directives. It is, therefore, essential to know our citizen volunteers well enough to suggest responsibilities and jobs that are appropriate to their talents and time pressures. The result is usually a greater percentage of completed assignments.

6. Since progress depends so much upon the work of committees composed of human beings, it goes without saying that the leader should have a reasonable understanding of individual, group, and community dynamics.

In conclusion, it is only as the citizen learns to participate maturely in the program at home that he can be expected to meet his ever-widening responsibilities to the mental-health program of the larger world community. And we need not look too far afield for our world citizen. Let us start looking among ourselves.

SAMUEL WARREN HAMILTON

WHEN Samuel W. Hamilton died in the office of the superintendent of the Rutland State Women's Reformatory, Vermont, on July 27, 1951, American psychiatry lost one of its grand old men, mental-hospital staffs their most trusted counselor, and many of us, both inside and outside his profession, an irreplaceable friend.

The end came as he might have planned and wished it—while he was working for the betterment of the lives of people in an institution; without fanfare, melodrama, or long-drawn-out preliminaries; and in his ancestral town. And as characteristically right and fitting as his death in relation to him and his life is his body's interment between Vermont hills. In their simple, unobvious grandeur, they are so much like him who, for all his national and international fame, always remained a part of them, that it seems as if landscape and the spirit of the man were almost mystically blended.

The skeleton biographical facts of Dr. Hamilton's life add up to a story of step-by-step professional training and experience which led ultimately to eminence in his particular field of practical applied psychiatry in institutions. He was born in Brandon, Vermont, August 21, 1878, a descendant of New Englanders of Scottish stock who had been in this country since the seventeenth century and among whom had been many physicians. The young Hamilton attended high school in Rutland, was graduated from the University of Vermont in 1898, and received his M.D. from the College of Physicians and Surgeons, Columbia University, in 1903. After serving his interneships in the New York City Children's Hospital and New York Lying-in Hospital in 1905, he held a series of positions in the kind of hospitals which were to be his major concern—assistant physician at Manhattan State, senior assistant physician at Utica State, medical director at the Philadelphia Hospital for Mental Diseases, and assistant director at Bloomingdale Hospital, White Plains, New York. There were also periods of teaching—at one time, of classical languages; at another, as associate professor of psy-

chiatry at the University of Pennsylvania Postgraduate School of Medicine; of psychiatric work at clinics; and of war service as a commissioned neuropsychiatrist, 1917–1919.

As early as 1916, with a survey on the "Care of the Insane in Colorado," Dr. Hamilton began to be called on to make reports upon institutions as they are and to recommend what they should be. His earliest surveys were made as director of the Division on Hospital Service of The National Committee for Mental Hygiene. From 1936 to 1939, he was director of the Mental Hospital Survey Committee; and in 1939 he was appointed mental hospital adviser of the Division of Mental Hygiene, United States Public Health Service. As the "psychiatric circuit rider" he called himself, the continual, extensive traveling he did, the miles of wards and corridors he covered, would have exhausted a less inspired man.

Samuel Hamilton was president of the American Psychiatric Association for the year 1946–1947, a time when there were evidences of dangerous internal dissension which, as a non-member, I would not attempt to define or detail. Suffice it to say that under his hard-working and tactful presidency, any irreconcilables seemed to have become reconciled. At the 1947 annual meeting which terminated it, the boys in the press room were hard put to it to get any stories about intra-organizational fracases because everything had become unnewsworthy sweetness and light. At the 1951 annual banquet, Past-President Hamilton received the largest ovation of any of the brass who filed up to the head table.

Dr. Hamilton resigned from the U. S. Public Health Service to become superintendent of Essex County Hospital, Overbrook, Cedar Grove, New Jersey. Here the surveyor, as administrator, had a chance to apply some of his own advice. He held the post until 1950, when he and Mrs. Hamilton moved back to settle in Burlington in their native Vermont. During the winter of 1951, he had a bout with pneumonia, but otherwise he remained active as a consultant until the very moment of his death.

No one was such a gold mine of information about institutions. It was not only that he had piled up dozens upon dozens of detailed surveys of mental hospitals and state schools; that to professional journals he had contributed

numerous papers, with some, of his later years, still unpublished; that he had written a definitive history of mental institutions for the centenary volume of the American Psychiatric Association. He was also a verbal encyclopedia. Offhand, he could tell you who was the superintendent where in what year, and what was the patient capacity of a particular hospital. The now defunct *New York Sun* used to have a slogan, "If you see it in the *Sun,* it's so." It could be paraphrased to apply to Dr. Hamilton—whatever he gave out as a fact, every one knew was so.

Those of us who sought from him not only facts, but also advice, whether on professional or personal matters, were beneficiaries of a rare kind of wisdom. Nuggeted, often, in a terse, satiric phrase, it was a combination of homespun common sense with erudition, of mature experience with fresh thinking. Overdependence upon him would have been easy, but, like a wise parent and an able psychiatrist, he would not permit it. He told me, for example, "You must not let yourself become associated with only one psychiatrist," and, partly perforce, when he left Washington, I took his advice. Yet I still have the impulse, as strong since his death, to find out "what Dr. Hamilton thinks about it." There are many others who feel the same way.

Personally, Samuel Hamilton had a New England reserve which reached heights in the dignity of a man always in control of himself and of situations. No matter how warmly he took you into his friendship and home, no matter how much he let you involve him in your troubles, he never indicated his own. Perhaps this is the essence of a great psychiatrist. It certainly is the essence of a great man. The reserve was verbal, too. Like Calvin Coolidge, a character about whom he loved to tell anecdotes, he never said three words when one would do and even that one would be circumspect.

His surveys are characterized by this same reserve, and like any man so incorruptible, so quietly forceful, and so determined to do what every one thinks is right only in the way he thinks is right to do it, Sam Hamilton had critics, among the most vehement some of my colleagues in journalism. His mild, understated reports and recommendations, they allege, held up rather than helped progress in mental hospitals. There is no denying that the surveys are circum-

locutious. Indeed, I once parodied them with "It is thought that the patients would be more comfortable were they not sleeping three in a bed." But what must be understood is that both their manner and substance are an expression of strength, not of weakness. He said what he said in the way he said it out of a positive conviction as to the best way to bring about improvement. When he used pale language about conditions that some of us would have exposed in red and purple, it was because he was too wise and experienced to think that the shock treatment of a "clean sweep" could bring about any long-term changes; because he was too practical to advocate impossibilities; because he felt that making the most of what good existed, however little, was preferable to scrapping any grains of gold with the dross; but, above all, it was because, as he once said to me, "I want to be asked to come back." His function was not that of a policeman, but of an adviser; he went into institutions, not by warrant, but by invitation.

And he *was* asked to come back, sometimes to find that depressingly little had been changed, but more often to see that here and there, in the small ways which can be so big to patients, his recommendations had been followed. Should a modern artist paint a Last Judgment, with betterment of mental hospitals one of the criteria, whoever realizes what Samuel Hamilton set out to accomplish and did accomplish will have no doubts about the side on which he would be.

Underlying everything he did, both professionally and privately, was an enormous kindliness. He had a profound love of humanity—in the mass, in special groups, and as individuals. But like the grim facts of institutional life which were partially obscured by his tempered wording, his feeling for people often took cover under facetiousness.

So unsentimental was his sentiment that it took time to appreciate the vastness of his love. He had it, of course, for his family—for his wife, Ruth Norton Hamilton, who survives him, who devotedly suited her life to his while retaining her own stature; for the daughter whose untimely death he took with fortitude, and her husband; for his son and his son's wife. He had it for children, not only his own grandchildren, but also numerous youngsters with whom he maintained a steady postcard correspondence. He had it

for his friends and co-workers and all the unfortunates of the earth. He had it, too, for the institutional doctors and nurses and attendants whom he might have put under fire. His love was so great it embraced the fact that most of us do the best we know how.

EDITH M. STERN

BOOK REVIEWS

THE FAMILY: A DYNAMIC INTERPRETATION. By Reuben Hill. New York: The Dryden Press, 1951. 637 p.

Some thirteen years ago, the late Willard Waller published a book on the family, utilizing a considerable amount of new case material gathered from students, and interpreted with heavy infusions of Freudian principles. While criticized by some for its non-statistical procedures and psychoanalytical emphases, it was equally defended for its unique insights and provocative approach. Through the years since, it has found wide usage as a college text in courses on the family. More recently, Reuben Hill, research professor at the Institute for Research in Social Science at the University of North Carolina, was asked to revise this work, and the present volume is the result.

By comparing the two volumes, the following facts appear. The Hill revision shows 16 more pages than the Waller book, the number of chapters is increased from 22 to 25. Eight chapters are wholly or almost entirely new. These deal with the family as an arena of interacting personalities, the engagement, the imposing relations of parenthood, family crises, and proposed changes in family design. Ten chapters, dealing with the social self, habit formation, courtship, marriage conflict, and divorce, are retained from the original volume, with slight changes. The remaining eight chapters, devoted to love, selective mating, bereavement, and alienation crises, have been substantially reorganized.

These comparisons bear out the reviewer's conclusion that the Hill revision is to a large extent a new book. While it retains the more valuable parts of the original volume, it develops some entirely new areas and brings other parts up to date. If, in certain respects, the volume lacks the Waller fervor and intensity, it gains in breadth and comprehension. This is a more balanced book than the original, it is in many respects more useful, and it should prove to be highly useful as a college and university text, as well as for the general reader. What particularly pleases this reviewer is the fact that, both in specific chapters and sections as well as implicit between the lines elsewhere, is a recognition of the fact that families have children and grandchildren and relatives. So much of the literature on the family seems to imply that the family consists of a man and a woman, engaged in a romantic experiment which promises an interesting or even startling dénouement around the next corner, that this broader and more realistic conception of the family seems curiously novel.

In summary, this book is written with balance and insight, with a full knowledge of the literature on the family and without the regrettable habit of some writers of quoting and referring to only selected schools of sociological thought. Also, the publishers deserve special mention for the physical appearance and attractiveness of the volume.

JAMES H. S. BOSSARD

The William T. Carter Foundation,
University of Pennsylvania

MARRIAGE. By Robert A. Harper. New York: Appleton-Century-Crofts, 1949. 295 p.

Industrial expansion, the migration of people from farms to cities, the entry of women into economic and social areas, the weakening of external pressure, the loss of many of the social, economic, educational, and recreational functions—these and other factors have changed the structure and function of American family life. In this transition phase from the older patriarchal system to a more democratic form, the stability of the family depends primarily upon its own resources.

Marriage involves two distinct personalities in a complex, ever-changing emotional relationship. The man and woman entering it expect to derive through each other satisfactions of their own basic needs for love, companionship, emotional security, sex, and parenthood. Yet there is nothing in the emotional development of an individual that specifically prepares him for the marital relationship. A good marriage is learned by precept and example, and only the conscious desire of both partners enables the relationship to be maintained. But rarely are young people to-day equipped to meet the requirements of a happy marriage.

Some of the answers to this need of young people to establish and maintain a happy and stable marriage are, Mr. Harper states: (1) expansion and coördination of family agencies; (2) marriage and family education; (3) counseling services; and (4) legal reforms.

As a sociologist, Harper is concerned with one aspect of this program: education for marriages and family life. In simple, clear language, his book provides an excellent text in courses for students in marriage and the family. With an unbiased and eclectic approach, he translates into language easily understood what is known and accepted about emotional development and behavior as it affects the marital relationship. Throughout, there are practical applications of psychodynamic principles realistically and clearly described. Yet he does not fail to discuss the responsibilities inherent in the rela-

tionship. As he states in his chapter on legal and community aspects of marriage: "American society has come in recent decades to place so much emphasis upon the importance of the successful adjustment or happiness of the individual in marriage that we are inclined to forget that marriage is a legal status and social institution. The individual who enters upon marriage forfeits an element of personal freedom for personal security and social stability."

The book, with its summary and questions for study at the end of each chapter, is an excellent text and will prove valuable not only to students, but to all professional people who are counseling men and women before and after marriage.

LENA LEVINE.

Marriage Counseling Service,
Mothers' Health Center,
Brooklyn, New York.

WOMEN IN MARITAL CONFLICT: A CASEWORK STUDY. By Florence Hollis. New York: Family Service Association of America, 1949. 236 p.

The author of this study, now associate professor of social work in The New York School of Social Work, Columbia University, has had wide and valuable experience as a practitioner, as a supervisor, and as an instructor in the field of social case-work. A graduate of the Smith College School of Social Work, she received her Ph.D. degree from the Carola Woerishoffer Graduate Department of Social Economy and Social Research, Bryn Mawr College. The present study was originally a dissertation completed as a requirement for the latter degree, but in the revision for publication, additional theoretical material has been developed to help the student place the findings in the framework of the psychological assumptions upon which most modern case-work rests.

Marriage conflict is causing increasing concern among students of social trends. Broken and unhappy homes breed warped personalities who in turn marry and create more unhappy homes into which more children are born. To break this chain of individual discontent and misery, approaches must be made simultaneously along many lines. Study of causes, study of treatment methods, and study of results will finally bring answers to these problems and help to break the destructive chain.

In the field of social work, the family-service agencies have been concentrating on study looking to the solution of marriage problems. Couples have come to family-service agencies because discontent and open quarreling have reached such a point that one

or both partners were considering separation, if such had not already taken place. Out of this background emerged the present study of one hundred family case records, after the completion of the treatment period. The case material studied was made available by eleven member agencies of the Family Service Association of America, including agencies in cities as widely separated geographically as Atlanta, Boston, Brooklyn, Chicago, Cleveland, Indianapolis, Milwaukee, New York City, Pittsburgh, St. Paul, and Washington. The sample thus selected seemed unusually representative of the average American family seeking help from a Family Service Association agency.

These cases were examined from the point of view both of the personalities of the women involved and of the external pressures to which these women had been exposed. The over-all impression left by the findings is that personality factors lay at the root of marriage conflict in these families. The psychological factor that emerged most clearly was emotional dependence, closely related to the question of parental ties, which were also studied. Other personality factors examined in detail were the "need to suffer" (technically known as masochism) and "rejection of femininity."

Treatment methods for these personality factors were described, classified, and evaluated. In such description a classification of treatment methods was utilized, based principally on the means by which change (or learning) was brought about. This classification can best be described by the use of four terms—environmental modification, psychological support, clarification, and insight development. These treatment methods are utilized in all types of social case-work, including marital conflict.

The final chapters of this study, which include a critical note on treatment practices, an evaluation of degree of change and quality of work, and a summary of the findings and implications of the study, are extremely valuable and stimulating for further and more intensive research, and for a better quality of treatment. The following definite recommendations are made: first, that the level of work of all case-work practitioners be brought up more nearly to that of the best workers in the field. Agencies must do all in their power to increase the skills of their workers by longer periods of professional education, by more regional institutes and in-service training, by competent psychiatric consultations, and by constant pooling of knowledge of all workers in this complex field—psychologists, sociologists, marriage counselors, physicians, clergymen, psychiatrists, and analysts.

One of the greatest needs of the case-work field to-day is better and more extensive research. For this there is needed not only

thorough knowledge of the subject, but months of concentrated work and adequate financial support. Future studies might well be based on records written specifically for the given study; evaluations should depend on the judgment of several highly skilled persons; studies should include a much larger number of cases to broaden the base of evaluation; and cases should be followed up six months or a year (or even longer) after the closing of the case, to check on development.

The present study has been conducted with great care and skill, and its findings and implications offer a real contribution to the solution of marriage conflict through more skilled treatment and a deeper understanding of the factors involved, which understanding should then be translated into preventive and educational work. Women's rôle in marriage is in great need of further clarification in order that happier and more healthy families may be more frequent in our democratic civilization. This study makes a real contribution to such an end, but also points to more important and more extensive steps that must be taken in the future.

AMEY E. WATSON.

Marriage Council of Philadelphia.

JEALOUSY IN CHILDREN. A GUIDE TO PARENTS. By Edmund Ziman, M.D. New York: A. A. Wyn, 1949. 236 p.

In his introduction to this book, Dr. William L. Granater makes the statement that, were he asked to name the one problem that most frequently troubles parents, he would select jealousy. It is a basic human emotion. It is manifest in almost every case brought to a child-guidance clinic. Parents need help in learning how to accept jealousy in themselves and in others before they can deal with it constructively in their children.

Dr. Ziman says that a child is jealous when he wants something that some one else has. This something for a young child means basically love, understanding, and protection. Jealousy in a child is normal; it does not mean that he will necessarily become a jealous adult. Malicious behavior, although in itself only a symptom, can become harmful when it arouses disapproval in his parents and he is made to feel himself wrong or bad. Parents need to understand what lies back of his behavior and to learn how to help him to accept his feeling of envy without arousing in him a sense of guilt that may impede his progress toward full maturity. Many case histories of adults are cited to show the harm that has been done by faulty handling of the symptoms of jealousy.

The first five chapters are a discussion of the general subject. They deal with the signs and causes of jealousy, the guilt feelings of parents,

the need for sympathy and understanding rather than of punishment ("Spoil the child and spare your rod," Dr. Ziman says), and the first steps in handling the problem. Dr. Ziman sees things through the child's eyes and presents his case in a way that cannot fail to give parents new insight. He knows that children are not just small adults, but are already individuals with their own thoughts, feelings, and relationships. He inspires faith in the inherent capacity of the child to develop into a wholesome personality, provided he is not permitted to become blocked by an accumulation of unresolved fears and resentments.

One chapter each is devoted to the problem of jealousy in the oldest child, in the second child of two, in the second child of three, in families in which the children's ages are close together, in which they are five years apart, and in which they are many years apart. Then follow chapters that discuss rivalry between the sexes, step-parents and step-children, twins and the importance of avoiding comparisons, with a final chapter on "the average family." Case histories are used freely.

Although jealousy is the starting point, the book really covers practically the whole field of parent-child relationships. It will be found invaluable to parents and should be read by pediatricians, teachers—by every one, in fact, who has the responsibility for helping children to grow up.

JULIA MATHEWS.

Hermosa Beach, California.

CHILDHOOD AND SOCIETY. By Erik H. Erikson. New York: W. W. Norton and Company, 1950. 397 p.

The tremendous activities of psychoanalytic research and treatment during the last fifty years seem to call for a recapitulation and a reintegration with the social sciences. The libido theory, the analysis of the ego, the extension of analytic treatment to character neuroses, psychoses, and personality deviations manifested in social misbehavior, all have pointed up the need for a résumé of the place of analytic findings in the evolution of the psychobiologic-social unit. This task of reviewing the interrelationships of psychoanalysis with sociology, anthropology, and psychology has been recognized by one of our leading analysts, Erik H. Erikson, and the nodal point of the twentieth century seems to be a happy point historically for such a revaluation. In a disquieting atmosphere of uncertainty and tension, with reports and studies of social-psychological phenomena pouring in, with the urgent need for a deeper understanding of the origin and vicissitudes of social and individual trends, Dr. Erikson has tackled the complex and challenging problem of carving out a coördinated social psychiatry.

To this task, he brings a unique appreciation of the clinical meaning of the child's maturation in instinctual terms, a "keen sense of history" (Kluckhohn), and a felicity for meaningful phrases that tends to hide the profundity of his thinking about people and society. In essence, his approach is an integration of the development of the child's instinctual life with the modalities of social life.

At each crisis in the child's development in which instinctual forces meet modes of social behavior, through identification with parents, teaching by collateral individuals, and contact with social institutions, Erikson traces the effects of social configurations on the character defenses the individual develops. Put in another way, he considers the social implications of the activity that develops from emotional investment in each body zone. His purpose is to "search for the proper place of the libido theory in the totality of human life" (p. 60). In doing this, he details the time-table of libidinal development as it meets social modes, to result in fairly standardized ego structures. This would include, for example, the relationship between incorporative influences affecting the oral and the anal zone and social teachings regarding "getting," "biting," "moving," and so on.

The resulting "societal dilemma" is further developed in various cultures (American Plains Indian, Coast Indian, adolescence in American boys, and European cultural areas). The total picture evolved gives considerable clinical meaning to the "abnormal" pattern reactions that children develop on the basis of conflict (or identification) of their own with parental responses in their milieu.

The Plains Indian, the Sioux, is contrasted with the Yurok Indian, a tribe of fishermen on the Pacific Coast, as these two cultures demonstrate how basic social modalities passed on by education relate to economic life (buffalo hunters as against salmon fishers) in determining the resultant character of the individual. As Erikson observes (p. 165), "in looking at cultures . . . the psychoanalytic observer weighs themes which appear on a dynamic scale in a culture's collective behavior. . ." In this way, the meaning of the ego structure from infancy to maturity, with its normal or neurotic projections into behavior, becomes clear within the setting of a culture.

From a study of these two preliterate cultures, the author goes on to show how social attitudes toward play, work, growth, and activity form the dynamic background and behavior patterns in our children. This, in turn, helps one to understand the symptoms of child neuroses and psychoses in a way that transcends the one-dimensional view of a child as an organism developing out of a parental environment only.

The range and viewpoint of the book are distinctly clinical. As expressed by the author (p. 237), "In this book we suggest that, to understand either childhood or society, we must expand our scope to

include the study of the way in which societies lighten the inescapable conflicts of childhood with a promise of some security, identity, and integrity. In thus reinforcing the values of the ego, societies create the only condition under which human growth is possible."

Pursuing this idea, Erikson discusses American identities—*i.e.*, identities with American ideals both economically and geographically determined—with special reference to the development of prejudice and national myths which unconsciously impel Americans to act as they do. This is contrasted with the identities to which German youths were subjected, as exemplified by the Hitler Youth Movement. Later the identities that surround Russian youth are also analyzed, as typified in a motion picture of Maxim Gorky's youth. The three contrasting cultures demonstrate how unconscious forces embodied in national ideals, myths, and ways of handling infantile anxieties and insecurities are merged in a specific way for each culture and then emerge in the individual ego structure.

It is impossible to summarize this book except to say that Erikson has thoroughly thought through the implications of clinical psychoanalytic findings in children in relation to social identities within cultures. Yet the author's summary—"I have nothing to offer except a way of looking at things" (p. 359)—covers a vast, profound clinical experience and imparts a satisfying frame of reference to the reader. No therapeutic panaceas are offered, but the author is concerned with the confusion of present-day international living and feeling in society and in individual patients. His therapeutic efforts are focused on achieving "a relaxation of unconscious superstition in the handling of infants and on the political and economic means of assuring a sense of identity to growing children" (p. 373). His thinking is specific, yet universal; clinical, yet practically theoretical.

To this reviewer, it seems as if Erikson were lifting his head from the grind of daily work of analytic treatment to the larger implications as he sees them in his patients. He uses a frame of reference that should be part of the instinctive equipment of every psychoanalyst or psychiatrist, even though he may not have the total information with which to appreciate social forms and their reflections on ego values.

To return to the metaphor used above, this reviewer feels that Erikson's book is itself a nodal point in the convergence of clinical psychologic sciences with the social and political sciences in our psychologic century. It is the work of an imaginative, a facile, and, scientifically, a completely honest man. It represents a high point in modern psychiatric achievement.

WALTER BROMBERG.

Reno, Nevada.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Vol. V. Edited by Ruth S. Eissler, *et al.* New York: International Universities Press, 1950. 408 p.

This publication maintains the high excellence of its contributions in previous years. The contents are so varied that it lends itself rather to a general evaluation than to a specific discussion of the individual articles, each of which in itself could very well be the stimulus for an individual review.

The acculturation of the arts and sciences through psychoanalysis is expanding. Herein the orthopsychiatric implications are approached, with psychoanalysis as lever and wedge. In many ways this is a broadening and deepening of the earlier American orthopsychiatric trends. For our survey, this volume can be divided into two aspects—research and technique.

Research.—Research into the ego includes the work of Hartmann, Hoffer, Kris, Loewenstein, Rank and Macnaughton, and Spitz. The essence of their investigations is that no longer can the ego be regarded as originating from the id. The two are disparate elements in the mental structure. To quote from *Development of the Body Ego,* by Willie Hoffer: "They [Hartmann, Kris, and Loewenstein] suggest with the support of impressive arguments that the ego should no longer be considered the result of differentiation from the id, but that both the ego and the id should be conceived the result of differentiation from an undifferentiated state." Just when this takes place is the challenge that Hoffer takes up, and in a provocative article, he evaluates the evolution of self, body, and object through the interrelationship between mouth-ego and body-ego.

Kris, in turn, in a comprehensive survey, evaluates this current contribution to the problem of psychology, and among other pertinent observations mentions the fact that growth is not possible without anxiety. He likewise reminds us how little we know of the self-healing process inherent in our maturation. One might, at this point, skip to *On the Sleep Disturbances of Early Childhood,* by Fraiberg, in which some light is shed on the anal contributions to ego evolution. Loewenstein carries the review to the phallic level, interrelating with Hoffer the consideration of the problem of aggression.

The research aspects in this section of the volume are emphatically in the area of the ego, and with each successive publication it is interesting to note how new light is cast upon this aspect.

Technique.—In no area of contemporary psychology is there so much experimentation and flexibility with regard to technique as there is in the field of child analysis. Rangell, in a communication somewhat reminiscent of Chesterfield's letters to his son, carries on a long-distance treatment through the medium of letters, and indicates

how far, with this tenuous contact, you can get in the simple treatment of common disturbances, provided you have intelligent parents with love as an incentive. Although the parents in this case were by no means sensitized to psychoanalysis, the successful resolution of the nightmares of a seven-year-old boy was achieved in this manner.

Miss Schwarz, in the pattern of Melitta Sperling, works with a parent and child in the consulting room, a technique particularly applicable when anxiety is great and parental attachment overdeveloped, and as a step toward individual therapy. Necessity often creates special tools when case loads are heavy and therapists are driven. Bonnard, working through a mother, under these limitations was able to accomplish considerable amelioration in the case of an obsessional neurosis.

Jackson and Klatskin, in their *Rooming-in Research Project,* give an evaluation of pediatrician-obstetrician liaison, with emphasis on methodology.

Kennedy contributes to the problem of cover memories in formation. In his original work on schizophrenia, Katan maintains that this condition is not preceded by an infantile psychotic state, and that psychosis differs from neurosis in that there is always an infantile base for the latter. The evolution of delusions is explained on the premise that they contain a solution of the danger situation against which no defense on a reality basis was possible. He contends that during the pre-psychotic period these cases do not undergo the Œdipus complex, and is quite insistent, contrary to common belief, that an infant does not pass through psychotic phases.

Eissler, in an article on the psychoanalytic treatment of delinquents, suggests some modification in therapy by a rôle of permissiveness in its early aspects and encouragement of a sense of the omnipotence of the rôle of the therapist. Then, only, can the traditional classical analytic approach be instituted. This, however, necessitates a change of analysts. Bettelheim's and Sylvester's contribution in this field is an interesting discussion of "Delinquency and Morality."

Early sexual development is ably discussed by Greenacre and Jacobson—special problems in early female sexual development by Greenacre, and the wish for a child, which she has uncovered in her work with boys, by Jacobson. There is an article by Lampl-De Groot on masturbation, which reviews contemporary and past literature on the subject.

Anthropology as a field that has much to offer in regard to reality evaluation is explored by Wolfenstein in *Some Variants in Moral Training of Children.*

If we are to judge by Beres' and Obers' work, there is a hopeful note to serious deprivations in infancy, through therapy. This is par-

ticularly encouraging for those who work with such children as Spitz has described—the foster-home personality and the orphanage resident. A sedimentation of impressions of all these articles indicates that the concepts of technique are indeed becoming more flexible.

The note upon which the volume ends is a sanguine one. As our knowledge of treatment as applied to specific clinical problems broadens, and as our theoretical knowledge deepens, many of the bleak prognostic areas become somewhat more infused with optimism. One aspect of adult psychopathology—namely, the manic-depressive constellation—is still a silent area. It is a challenging question how much of this worthy work can be applied to adults, and whether the therapeutic tools sharpened in this exploration could not materially further our treatment of adults.

For their zealous and timely contributions, we owe much to the workers whose research is recorded in this volume.

EDWARD LISS.

New York City.

YOUR CHILD AND YOU. By Cecil Hay-Shaw. London: John Murray, 1949. 157 p.

In the introduction to this book, the author states: "There seems to be a need for a really simple work [for parents] which can be easily read." For the most part this goal is attained. The book is written in a clear, "feet-on-the-ground" manner, and is free from technical terms. There is an occasional tendency to loose thinking, as when the author speculates on what the frustrated infant might be "thinking." The result is a projection of adult thought into the mind of the infant. (Thus, in Chapter I, it is stated: "One might easily imagine him wanting to return to the warm and comfortable place from which he came.")

The first knowledge of love and hate is said to be based upon the child's experiences with the mother's breast. This type of statement is in keeping with the present-day fallacy of thinking that we have "explained" something fully when we have followed it to its beginnings and reduced it to its "elements."

The advice given to parents is practical and based upon the sound principle that "every baby is different from all other babies."

The frequent reassurance of parents is an important contribution of this book. In Chapter 14 the author states: "Parents are apt to feel that whatever goes wrong with the child is due to something they have done wrong, but this is not necessarily so. Some children are much more difficult to bring up than others. Some have a tendency to retreat from life from the very beginning."

The chapters on "Personality Disorders" and "Treatment" are well written. They are the result of many therapeutic experiences with a variety of children's problems in the setting of an English child-guidance clinic.

The theme of the book is restated in the Conclusion: "As parents you will need a lot of patience, but patience comes with love and understanding."

The author has succeeded in presenting "useful facts about children and their problems in a simple, clear-cut manner." The book can be recommended to all parents.

J. H. Conn.

Johns Hopkins University School of Medicine.

Adolescent Development. By Elizabeth B. Hurlock. New York: McGraw-Hill Company, 1949. 566 p.

A suitable text on adolescence has been an acute need for many years. The present range of choice is strictly limited. In the order of their publication dates, the possible texts are as follows: *Adolescence*, Part I of the Forty-third Yearbook of the National Society of Education;[1] *Adolescence and Youth*, by Paul H. Landis;[2] *Psychology of Adolescence*, by Karl C. Garrison, third edition;[3] *Psychology of Adolescence*, by Luella Cole, third edition;[4] *Adolescent Problems*, by W. S. Sadler;[5] and now Hurlock's new volume. No other established area of instruction in psychology, education, or sociology presents such a limited and difficult choice and such a diversity of texts.

The Forty-third Yearbook is still the first choice of this reviewer. Its main limitation is that it was not written as a text for undergraduates. It lacks interest appeals. It is preoccupied with technical and research problems. Some of the sections are too difficult. A few are too thin or irrelevant. There is no discussion of health problems, of delinquency, of economic adjustments, of courtship and marriage problems. Nevertheless, it provides a dozen substantial and authoritative chapters by people who have made outstanding contributions to our understanding of this developmental period. Although its separate chapters are by different authors, it is more closely integrated than most texts. Although published in 1944, its material is not likely to be dated in the near future.

[1] Chicago: University of Chicago Press, 1944. 354 p.
[2] New York: McGraw-Hill Book Company, 1945. 470 p.
[3] New York: Prentice-Hall, 1946. 355 p.
[4] New York: Rinehart, 1948. 650 p.
[5] St. Louis: C. V. Mosby Company, 1949. 466 p.

For the many undergraduate groups that find the Forty-third Yearbook too difficult, the natural second choice, in the opinion of this reviewer, is the volume by Landis. The very serious limitation of the book is that it ignores and even belittles the importance of the whole range of biological factors. The few pages on the organic foundations of personality in Chapter 5 are weak and inadequate. There is no discussion of physical growth, body builds, sexual maturation, physiological functions, strength, motor skills, or intelligence. These are dismissed on the preposterous ground that their significance for personality has often been overemphasized. The great need, of course, is a serious attempt to understand how biological *and* social factors interpenetrate and mutually influence the development of personality. By the test of this need, the Landis book is not merely weak; it does a disservice to its readers.

In compensation, however, Landis has many solid merits. It is addressed to and has the necessary interest appeals for undergraduates. Its important contributions are in three major areas. Landis expounds with great skill a whole series of dynamic social factors which many psychologists tend to undervalue. These are rôle and status, rural and urban differences, social classes, peer groups, family influences, cultural factors, conflicting mores, social change, population shifts, technology, and so on.

The treatment stresses the problems both of adolescents and of youth. The bulk of the volume—Chapters 8 to 17, on moral maturity, marital adulthood, and economic adulthood—is concerned with problems of the late teens and early twenties. From the point of view of the needs of undergraduates, the discussion of these three areas compares favorably with comparable sections in the Forty-third Yearbook and is very decidedly superior to comparable (or nonexistent) sections in Garrison or Cole, Sadler or Hurlock. The final four chapters, a forceful statement of the implications of this material for education, make the book an appropriate text for teacher-training institutions.

Finally, the treatment in Landis' book has organization, continuity, and integration. It adds up and tells a consistent story. The book, however, is not suitable for more mature students; it is too thin and one-sided; it crusades, inspires, and occasionally preaches.

The volumes by Garrison, by Cole, by Sadler, and by Hurlock are very different from the Forty-third Yearbook and from Landis. They have many features in common. Garrison, Sadler, and Hurlock regard the adolescent period as one of turmoil, of storm and stress. Garrison, acknowledging indebtedness to G. Stanley Hall, presents a moderate statement, while Hurlock is extreme. Garrison, Cole, and Hurlock are zealous in summarizing the scientific literature. All three, especially Cole, are weak in evaluating this literature.

Hurlock and, in lesser degree, Cole try to summarize everything. Sadler makes no attempt to rely on research studies. All four fall far short of closely integrated statements. Sadler's book, in particular, can only be described as disorganized. Garrison's and Hurlock's are textbookish and formal. The Cole book is distinguished by its warmth, its case studies, and its frank appeal to undergraduate interests.

Landis would doubtless charge all four with biological bias. It is more correct to say that these volumes, especially that of Hurlock, are only dimly aware of the importance of social and cultural factors for the personality development of adolescents.

With this general evaluation as a background, we may note some of the distinguishing features of Hurlock's book. The introductory chapter contains many examples of the turmoil, storm-and-stress theory of the adolescent period. Typical passages are as follows:

> "Early adolescence, which follows the onset of puberty, is accompanied by awkward, shy, self-conscious behavior. This behavior is the direct outcome of rapid physical growth, with lack of sufficient time for the young adolescent to learn to coördinate his suddenly enlarged body, as well as the outcome of the development of new and stronger impulses and drives" (p. 4).

> "There are an increase in recklessness of behavior, lack of consideration for others, rudeness and gruffness of speech, and roughening of language—as shown by an increased use of swearing and slang. There are secretiveness about personal affairs, moodiness and brooding, intolerance of others—notably the younger children in the family—and greater demands for money to spend as the adolescent pleases. The adolescent resists advice, frequently doing just the opposite of what he has been advised to do; he is less demonstrative toward members of the family than ever before; he scorns sentiments of all kinds; and he delights in eccentric methods of dressing, going to the extreme of wearing shabby, dirty garments or of overdressing. The expressions of self-dissatisfaction and unhappiness listed above are all normal at this age. They show that the adolescent is going through an adjustment period, just as the temper tantrums of a 2- to 4-year-old show that he is trying to become independent by throwing off the yoke of parental domination" (p. 13).

> "Instability and inconsistency are indications of immaturity. At first, the adolescent oscillates between selfishness and altruism, fervent activity and idleness, enthusiasm and boredom, deep religious interest and atheism, self-confidence and self depreciation, conservatism and radicalism, and wisdom and folly. Moderation is little known to the adolescent, who shows excesses in every undertaking" (p. 14).

There is a notable absence in these quotations and elsewhere of the qualifying words *often, sometimes, occasionally, many, some,* and *few.* The clear implication throughout the discussion is that physical and biological factors are responsible. Yet all this is categorically

denied in a few lines on page 9: "That adolescent storm and stress is caused by socio-economic rather than physical conditions is shown by the fact that among primitive people and in ancient civilizations . . . no such condition existed."

Typical examples of merely summarizing available studies appear in Chapter 2, on puberty changes. Pages 28 to 31 summarize criteria of puberty. A paragraph is given to Crampton, a page to Leal, and two pages and twelve references to other criteria, such as urine analysis, menarche, estrogenic hormone, X-rays, and teeth. This is a hodgepodge list. It misinterprets several studies. It overlooks the excellent criteria of Greulich, whose studies are repeatedly cited elsewhere. The only evaluation appears in the final brief paragraph on teeth, which reads as follows:

> "There is also the technique of judging puberty by the appearance of the second molars, or wisdom teeth. When boys and girls start cutting their wisdom teeth, when their chests grow deeper, their shoulders broader, their limbs grow longer, and their feet and hands become bigger, one can tell, even without the use of X-rays, that puberty growth is taking place."

This is nonsense and it contradicts all that has been said in the previous three pages. Similarly, the section on the effects of puberty on behavior, pages 57 to 64, contains the following subheadings in bold type: *Bühler's Study, Hertzer's Study, Brill's Observations, Leal's Study, Stone and Barker's Studies, Sollenberger's Study, Hurlock and Sender's Study, Social Interests, Sex Antagonism, Sensitivity, Day Dreaming, Interest in Sex,* and *Peak of Difficult Age.*

The first two sentences of this last section read as follows:

> "As the boy or girl reaches the end of the prepubescent state just before sexual maturity is actually achieved (as judged by the standard criteria in use to-day), all the forms of unsocial behavior described above seem to intensify. The few months just before the menarche in girls and before nocturnal emissions, pubic hair, and other signs of sexual maturing in boys are unquestionably among the most difficult of the whole growth pattern."

Needless to say, there is not a scrap of evidence to support this statement.

The foregoing examples are typical. An examination of a random sample of pages indicates that more than half of the book consists of mere summaries of available studies. Indeed, the preface states quite frankly, "It is the primary purpose of this book to summarize recent studies of various aspects of adolescent development." In terms of the number of studies summarized, this objective should have been achieved. A twenty-three-page bibliography lists approximately 600 references, of which approximately four-fifths are cited

in the text. Yet there is hardly a paragraph on the topics that Landis regards as critical.

In a certain sense, this vast display is scientific. So-and-so found such-and-such and concluded this-and-that. The fatal difficulty with these merely factual summaries is that repetition, even for five hundred studies, adds up to nothing in terms of student understanding unless the author selects, evaluates, relates, organizes, and interprets.

A feature of Hurlock's book is the considerable space—all of Chapter 2, consisting of 42 pages—devoted to the processes of sexual maturation. This is a new feature in textbooks on adolescence. While Hurlock feels the need for justifying this space in the preface, this reviewer feels that the topic warrants still more space and that more of such material would be welcomed by college students. The several pages on the adult reproductive anatomy of males and of females is a model of good exposition. Unfortunately, it is here, and in Chapter 3 on physical growth, that the text fails in achieving consistently good summarizing.

The major contributions of the book are the excellent summaries of the vast literature on social behavior, friends, interests, and attitudes. Chapters 5 to 13, much the larger part of the volume, are concerned with these topics.

FRANK K. SHUTTLEWORTH.

The City College of New York.

ADOLESCENCE, ITS SOCIAL PSYCHOLOGY. By C. M. Fleming. New York: International Universities Press, 1949. 262 p.

This book is a compendium of work in the field of adolescence, interpreted and viewed through the eyes of the educational psychologist. The review covers work done from the time of G. Stanley Hall to the present, and includes material prepared by psychologists, anthropologists, sociologists, psychiatrists, analysts, and pediatricians.

Mr. Fleming takes a stand against that pioneer student of adolescence, G. Stanley Hall, objecting to his dividing the life development into fixed compartments for which completely different educational techniques should be used, the type of technique being determined by fixed conceptions about the characteristics of the child at each age, rather than by his individual needs.

Mr. Fleming holds too, that Freud's view of adolescence, as early stated, is one-sided and thus subject to criticism. He objects to the idea that adolescence must necessarily be a period of essential battle—the struggle of the child to overthrow his parents. He maintains that this hypothesis is unproven, and that, with understanding parents, no such life-and-death struggle is essential. Again, he objects to drawing generalizations about the fixed and essential characteristics

of each year, and stresses the idea of completely individual physical and emotional growth phases and thus psychological needs also individually determined.

He further points out that both Freud and Hall postulated differences in adolescent and adult male and female psychological characteristics that may have been absolutely definable in the cultural setting in which these men lived, but that are certainly no longer fixed points of departure for logical thinking in the middle of the twentieth century, and in the Anglo-Saxon world.

The book contains an excellent review of work on the parent-child relationship, and especially the social characteristics of children brought up in homes with overprotective or rejecting parents. Sociological and cultural factors are stressed and carefully reviewed. Much space is given to social development, group organization, and dynamics, and the problems involving status needs and struggles. Sociometry is defined and reviewed with sympathy.

The author has special understanding of the social needs and struggles of the adolescent. He goes on to choice of career, vocational guidance, and counseling. His attitudes about individual characteristics and differences are particularly fruitful in this area, since he recognizes the importance of seeking out each adolescent's aptitudes and weaknesses and setting up educational and training programs on a completely individual basis. The goal in view is to give the child areas of satisfaction and fields of service and emotional reward that can always be found and planned for if one sees the child as an individual rather than as, say, "a typical 15-year-older."

One of the most useful aspects of the book is the excellent bibliography appended to each chapter. The references are complete in the areas the book covers except for one paragraph in the last chapter, in which the author states: "It is known that stimulation combined with acceptance and encouragment at an early age can improve measurable intellectual performance so much that the mental ratio or intelligence quotient may be significantly raised." This may be "known," but it is not known to me, and no reference supports the author's contention.

Every person who writes a book on any topic will necessarily slant the emphasis in the direction in which he organizes his life's work. Therefore, it is but slight criticism to comment that Mr. Fleming views the adolescent as a socio-cultural-intellectual unit, and hardly recognizes with more than a passing nod the psychosexual growth, development, stresses, and needs. Nonetheless, this is a useful and, for the most part, a wisely written book.

MARGARET C.-L. GILDEA.

St. Louis, Missouri.

THE EDUCATION OF EXCEPTIONAL CHILDREN. Forty-ninth Yearbook, Part II, of the National Society for the Study of Education. Chicago: University of Chicago Press, 1950. 350 p.

Unlike many yearbooks of the National Society for the Study of Education, this is not a report of the discovery of new material, but is a description of the ways now being used to help exceptional children in the schools. One chapter is devoted to each type of exceptional child (the visually handicapped, the acoustically handicapped, children with speech handicaps, the orthopedically handicapped and the cardiopathic, the epileptic, the tuberculous, children with glandular disorders, the mentally handicapped, the gifted, and the socially maladjusted) giving the frequency of occurrence of such children, methods of identifying them, the special needs of each group, and some of the methods that have been found helpful in their educational development.

Each chapter is written by a different individual or group of individuals, so the point of view varies somewhat from chapter to chapter. Some chapters emphasize codified techniques; others emphasize rather the adaptation of these to the individual child's emotional needs. Though in each chapter the attitude is expressed that we are teaching not the handicap, but the child, still it is apparent, from the different emphases of different writers, that this attitude permeates the work of some teachers more than of others. The individual teacher must be making constant informal evaluation of each child's emotional needs and personality development, and her whole utilization of methods will be infused, illuminated, by her understanding of him as a person, his moods, the reasons for his particular plateaus in learning, his shifts in morale, and so on. All the skillful methods in the world can fail without this creative understanding on the part of the teacher who applies them. This yearbook gives only the skeleton of the education of handicapped children; the skeleton must be filled out and vitalized by the individual teacher.

To the reviewer, more time and energy seem to have been expended in evaluating the exact degree of handicap than in estimating the child's strengths of physique and personality. Both types of estimate are needed. The research projects suggested by Dr. Kirk in the last chapter indicate that much critical thinking and planning are now being directed toward this prognostic goal.

RUTH M. HUBBARD.

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CHILD TREATMENT AND THE THERAPY OF PLAY. By Lydia Jackson and Kathleen M. Todd. Second edition. New York: The Ronald Press, 1950. 159 p.

This small book has two forewords—one by Helen Ross, the other by Emanuel Miller, Lt.-Col., R. A. M. C.—as well as a preface by the authors. There are eight chapters: *Theories of Play*, *"Father to the Man,"* *Parent-Child Relationship*, *Breaking the Vicious Circle*, *Play as Expression of Conflict*, *Work with the Parents*, *Play as a Method of Treatment*, and *Some Aspects and Phases of Therapeutic Play*. A short bibliography, an index of authors, and a subject index complete the contents.

The first chapter is exceedingly brief. It refers to theories of play advanced by Karl Groos and William McDougall, both of which the authors consider inadequate. They describe other elements in the child's play, such as expressing emotions that have to be repressed in the child's daily life relationships to other people; learning control of these emotions; gaining a sense of mastery by imaginative play, as when the child plays that he is doing to others unpleasant or painful things which he has previously had done to him; relieving guilt through dramatic play in which the child identifies with the victim who is punished, injured, or killed, and so on.

These views on the psychological meaning of play are decidedly reminiscent of statements made by Robert Wälder, in 1933, in his paper, *The Psychoanalytic Theory of Play*.[1] Particularly, Dr. Wälder gave a lucid presentation of the way in which children are able to master traumatic experiences. Hence it is surprising to find no reference to his paper. One can only assume that the authors of this book had not discovered his earlier contribution and arrived at similar conclusions from their own observations.

The second and third chapters focus on the child's emotional development as affected by cultural pressures and family relationships, with emphasis chiefly on what happens in the first years of life in connection with feeding, weaning, toilet training, and so on. Diagnostic and treatment procedures are the themes of the fourth chapter. There is brief reference to some of the different kinds of therapy. The authors state that their own viewpoint is eclectic. They also state that in working with children, a therapist must be tolerant, free from prejudice, open-minded, prepared to learn from each patient, and able to be passive and receptive for long periods at a time, permitting initiative to the child.

The first four chapters, outlined above, contain little that will seem

[1] *Psychoanalytic Quarterly*, Vol. 2, pp. 208–24, April, 1933.

new to child-guidance workers. The same may be said of the sixth chapter, which gives an account of social case-work with parents. The most interesting chapters are the fifth, seventh, and eighth, in which the child's play is discussed in some detail.

In Chapter 5, there are nice distinctions between normal and neurotic children with regard to such aspects of play behavior as inhibition, destructiveness, immaturity, regression, obsessional behavior, and hyperactivity. Chapter 7 uses case material to illustrate the ways in which children play during treatment and the values of the play from a therapeutic viewpoint. The eighth and last chapter is perhaps the most thought-provoking. It offers some explanations for the therapeutic aspects of play—such as reliving play phases that may have been aborted or skipped in this child's development, catharsis through play, and the like. There is also an attempt to differentiate between the types of play typical for the child whose neurosis has resulted from some traumatic experience, and for the child whose neurosis has grown out of long-standing family attitudes unfavorable to healthy emotional development. Where the child has long been the victim of unwholesome parental relationships, there is more likelihood of an obsessional neurosis, in the opinion of the authors. They point out that this is apt to require a longer time for therapy and for case-work with the parents.

Although this is a small book, it well repays the reader, for it is soundly based on clinical experience and it is written with simplicity and clarity.

PHYLLIS BLANCHARD.

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CHILDREN WITH MENTAL AND PHYSICAL HANDICAPS. By J. E. Wallace Wallin. New York: Prentice Hall, 1949. 549 p.

From many years of teaching and practical work, Dr. Wallin has committed to textbook form the insights and knowledge he has gained concerning handicapped children. To say the least, this is a valuable contribution. The writing is primarily descriptive and is easy to follow. Technical terminology is translated into terms more meaningful to the layman. The generous use of citations and references to technical literature, and the adequate coverage of statistical facts, will be especially helpful to the serious student of the psychology of handicapped children. Although considerable space is given to descriptions of various conditions, there are good discussions of treatment and training. The possibilities and limitations of development and educa-

tion for many types of disability are considered realistically. The practical note throughout is particularly commendable.

Although the text heavily emphasizes mental retardation and feeblemindedness, approximately half of its chapters being given to this subject, there is adequate consideration of epilepsy, encephalitis, cerebral palsy, poliomyelitis, and various growth anomalies. This reviewer was impressed by the succinct presentations of historical material on various disabilities, showing how diagnosis, terminology, and understanding of these conditions have improved over the years. Chapters dealing with the definition of mental defect and with the differentiation between mental deficiency and mental disease are especially to be commended to persons in social work. The distinctions offered here are clear, making an adequate distinction between the technical and correct usages and the more common, but less correct, usages.

There are extensive expositions of various systems of classification for the mentally retarded. These discussions integrate the viewpoints of many experts, pointing out the practical advantages and disadvantages of each system. Dr. Wallin presents forcibly the case for the "multiphasic nature of a satisfactory classification of mental deviations" (p. 115 f.), showing how various classifications may overlap, yet support one another in describing the many varieties of exceptionality that exist. He finds, for example, that a classification by types of mental function, such as judgment, attention, speech development, degree of sensory defect, and so on, is helpful in some circumstances, and classification by educability and socio-vocational competency useful in others. Classification by etiology is handled in one chapter, and classification according to special clinical types, including endocrinopathic disorders and the usual discussions of cretinism, mongolism, and so on, is covered in several chapters.

Dr. Wallin's discussion of cerebral palsy is free from the sentimentality that often surrounds a child disability to which widespread popular attention is given. His treatment is straightforward, facing frankly the limitations on reëducation, but indicating the circumstances in which there is hope. He accepts as valuable the Kenny treatment of poliomyelitis, a position that is debated in medical groups. His consideration of the possible psychological concomitants or sequelæ of polio is quite brief, though the bibliography is reasonably complete.

Unlike some texts that summarize many years of the writer's personal study and experience, the book gives considerable attention to recent research and literature. As a whole, it is a fitting climax to

Dr. Wallin's years of noteworthy service in the field of handicapped children. It should be extensively used by student teachers, nurses, social workers, and others who come into contact with behavior deviations based on physical and mental handicaps.

DALE B. HARRIS.
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LOVE IS NOT ENOUGH. By Bruno Bettelheim. Glencoe, Illinois: The Free Press, 1950. 386 p.

This book is a report of the procedures developed for working with emotionally disturbed children at the University of Chicago's Sonia Shankman Orthogenic School. The author is not only the head of the school, but also associate professor of educational psychology in the departments of education and psychology at the University of Chicago.

The children reside at the "school" seven days a week for as long as their individual needs require; and, as most of them are very seriously disturbed at the time of their admission, they usually stay for several years. An educational program fitting into the total treatment plan for the children is provided on the same grounds.

Thus these children are completely removed from their former environments and from the adults who contributed to their difficulties. The counselors and teachers who now handle them attempt to make each life experience of the child pleasant and manageable for him. Eating, bathing, eliminating, going to bed and dressing in the morning, learning to read and to participate in education, all of these experiences the child finds very different at the school. Many children cannot form any significant relationship with the adults at the school for months, but eventually they reveal the trouble areas in which mishandling in the past has been so seriously damaging to them.

Always one learns much about normal developmental processes from observations of disturbed individuals, and the reports of the children's behavior that the author gives us add much to our understanding of all children. Chapter V, in which the author discusses "the in-between times" of the day, gives a particularly fresh approach and new insights into the often observed reluctance of children to move from one activity into another.

The methods developed for a gradual initiation of the children into the outside world offer many new ideas. Within the environment of the school, the children who need this permissiveness are allowed to dress oddly or to go without hair cuts, but they understand that the staff of the school will not participate in excursions outside of the school with them until they meet minimum standards of appearance. The staff thus protects the child from appearing strange or ridiculous

outside. One notes, too, the author's statement, substantiating less systematic observations, that there is a great decrease in illnesses among the children after a short period in the school.

Other publications about the school answer some of the questions that this book leaves unanswered. The author might wisely have let us in more on the thinking and experimentation that went into the development of some of the methods of handling the children.

The children are given opportunities for individual-therapy sessions with the psychiatrist, with their own counselor, or with some other staff member, depending upon their apparent needs. The observations on the ways in which the children use these individual sessions to supplement their other contacts, or to meet needs of the moment, are extremely interesting.

Mr. Bettelheim seems to imply in his introduction that the book is intended for parents as well as professional people. I would seriously question any wide use of the book with parents. One is dealing here with extremely ill children who have suffered gross mishandling prior to entering the school. At school they are handled by trained people under careful supervision. For the parent to attempt to make deductions about his child or his own handling from this kind of situation seems highly dangerous. One feels that the title of the book is unfortunate. Mr. Bettelheim is protesting against glib assumptions that a child's needs can be met by cursory showing of perhaps unfelt love in cuddling, fondling, and so on, assumptions that no thoughtful practitioner is making in any event. A title descriptive of the content of the book would be more appropriate.

One hopes that a future publication will discuss some of the administrative questions that are only touched upon here. One would like to know how the staff is recruited, trained, and supervised for such obviously consuming work, and something more about the planning that is done for the child after he leaves the school.

FRANCES P. SIMSARIAN.

Washington, D. C.

THE THIRD STRIKE. By J. Gray. New York: Abingdon-Cokesbury Press, 1949. 59 p.

The past decade has seen the thesis that alcoholism is a sickness, and the alcoholic capable of rehabilitation—and worth saving—accepted increasingly by professional groups and the public alike. During this period more books have been written on this subject, more speeches delivered, more motion pictures produced than in any other period in our history.

To the distinguished list of publications already produced now is

added Jerry Wald's *The Third Strike,* a book that is as poignant and incisive as it is short.

Writing under a pseudonym, Wald, in this aborted autobiography (he was twenty-seven when he died), describes the inexorable alcoholic trap in which he found himself and from which he was unable to escape. His story of the long-drawn-out battle with himself, as much as with alcohol, his descriptions of the horror of acute "alcoholic" hallucinoses and delirium tremens, will hold or repel the reader to the extent that the horror of Poe attracts or repels.

The essential tragedy of Mr. Wald, a young man of intelligence and considerable insight, was that he was unable to implement the insights that he had. He ran through the gamut of experiences from escape to the sea as a sailor, in order to overcome his addiction, to the Bellevue type of alcoholic ward. In the end, finding no surcease within himself and no satisfaction in alcohol, he died.

This, his story, a minor *Lost Weekend,* with flashes of brilliant prose, is both his epitaph and the indictment of a society that has been libelous in its labeling and callous in its treatment of these sick people.

JOSEPH HIRSH.

Medical Reference Board,
Hadassah and the Hebrew University.

JAILBAIT: THE STORY OF DELINQUENCY. By William Bernard. New York: Greenberg Publisher, 1949. 216 p.

This book impresses the reviewer as being sensational and superficial in the main. This impression is somewhat relieved by frequent references to various scientific studies that have been undertaken to discover the basic factors in delinquency and its treatment. But the chapter titles, the dramatic and unusual examples that are given as an indication of the usual and new developments in the field, the lack of perspective—all of these leave the reviewer wishing that the writer had used his undoubted talents for description in a more balanced and more constructive manner. We cannot see why it is necessary to take up so much space in rewriting all the sensational newspaper-reported accounts of quite obviously abnormal actions of abnormal individuals. These are not new types of behavior. They have been taking place in very much their present forms for generations.

In the reviewer's opinion, there is merit in emphasizing again that war and the conditions that accompany it bring serious disturbances to children and that these are followed by an increase in crime and all

forms of delinquencies when the children grow up. Child prostitution, gangsterism, truancy, theft, assault accompany and follow wars.

The author points out that children who grow up without love and affection, without wholesome recreational outlets, without a wholesome home setting and parents who take time to know what their children are thinking about and doing, furnish most of the recruits for the ranks of delinquents and criminals.

As an illustration of the need for prevention and the possibilities in that approach, he describes the St. Paul experiment of the United States Children's Bureau, in which the community resources were mobilized and guidance facilities established to work with children who presented problems in behavior and adjustment.

Under the headings, *Statistics of Sin, The Juvenile Prostitute, School Scandal, Vice and Private Schools, Sex Exploration, Hayloft and High School,* the author tells some lurid tales of what is happening in urban and rural areas in the field of sex delinquency. He points out that much of this is an aftermath of the general let-down in moral standards during the war. The reviewer remembers similar incidents after World War I. According to figures quoted from F.B.I. files, rural crime was increasing "three to four times as fast as city crime during the 1947–48 interval." He ascribes much of this to boredom, but also points out that sex indulgence frequently is the result of attempts of affection-hungry children to find companionship and acceptance. He arrives at the conclusion that at least two or three of every hundred babies are illegitimate. Adult example contributes toward the moral breakdown of youth. He also suggests lessening cultural tensions through teaching democratic respect for all individuals, close attention to early behavior problems, building up control, and temperance.

Under the title, *Cradles of Crime,* the author discusses the deplorable situation in regard to the detention of juveniles in jails that do not meet even elementary standards of decency, sanitation, or separation of juveniles from adult criminals. There are only a few bright spots in the picture in so far as detention of juveniles is concerned, but the increasing use of foster homes in certain areas is looked upon as constructive.

According to the author, the situation is still unsatisfactory in the area of juvenile institutions where inadequate budgets make it impossible to secure and to hold qualified people to do the very difficult job of diagnosing and treating the personality disorders of which delinquency is the symptom.

In the chapter on anticipating delinquency, emphasis is placed on the need for understanding that frustration of the human animal

always leads to aggression and that aggression is always a product of frustration. But, according to the author, there are other factors of importance. One of these is the problem of the withdrawn child. Some recent studies, such as the one by Wallace Ludden and the one by W. C. Kvaraceus, are described in some detail.

In attempting to place the blame for existing conditions, the author quotes from school authorities as to the important place that the school can occupy in preventing delinquency. He stresses, however, the responsibilities of the parents and the home in establishing basic attitudes and patterns of behavior in the child. The essentials which he believes that parents should give are listed as (1) affection, (2) respect, (3) security, (4) time and companionship, (5) family planning, (6) emotional stability, (7) a tolerant view, and (8) courtesy. The part that the police can play in forstalling delinquency and in curtailing it by establishing juvenile police is considered important. Particularly important are the development of social services and the establishment of child-guidance clinics.

Summing up, the author comes to the conclusion that there are four categories of cause. These are (1) lack of love, (2) lack of example, (3) lack of responsibilities, and (4) lack of natural equipment.

HERBERT D. WILLIAMS.

Juvenile Welfare Board,
St. Petersburg, Florida.

BE YOUR REAL SELF. By David Harold Fink, M.D. New York: Simon and Schuster, 1950. 307 p.

This book is charmingly written. The author has a clear understanding of the dangers that lie in careless wording. He acknowledges a debt to Alfred Korzybski in such chapter headings as, *The World of Not-Words* and *The Use and Abuse of Labels,* and in such statements as, "The 'is' of identification has led to more misunderstandings and fights than any other word." He also seems to have great faith in the power of the printed word to modify the behavior of patients. He says, for example (p. IX), "This book will first teach you how to relax."

The intimately personal case-history type of exposition presents ideas clearly and draws the reader on eagerly from page to page. The author states that every reader will find much of himself in each history because these histories are synthetic rather than individual. The text proves this statement. The histories are almost too human to represent any one human accurately.

The book is a pleasure to read. I believe that it can hurt no one and

it may help some. The content of the text is best indicated by some of the section and chapter headings and by certain quotations that can be removed, without great damage, from the context in which they rest:

Section I, *What Is a Nervous Breakdown?;* Section II, *The Three-pronged Attack on Unhappiness;* Section III, *How to Know Yourself and What You Want;* Section IV, *How to Think for Yourself.* Page 50: "Very few people ever question their own evaluations. People are not only rigid; they resent having to question and reëxamine their attitudes." Page 103: "Intelligent choice requires that you do not limit yourself by childish insistence upon evaluations that have not been checked for their validity." Page 198: "Yet misery and misunderstanding are as thick as mosquitoes in a swamp, simply because people do not know how to talk to each other or how to listen to each other." Page 224: "What *seems to you* seems something else to me. Try substituting 'It seems to me,' for, 'It is.' "

These quotations do not give any adequate idea of the author's style. The book is easy to read and you will enjoy it.

GEORGE H. PRESTON.

Ft. Myers Beach, Florida.

HANDWRITING ANALYSIS. By Ulrich Sonnemann. New York: Grune and Stratton, 1950. 267 p.

Interest in handwriting as a testing technic has undergone a noticeable revival within the last decade, with the result that more literature on the subject has become available in English. *Handwriting Analysis,* by Ulrich Sonnemann, is one of the more recent attempts to acquaint the layman with handwriting analysis and instruct him in the graphological method.

The book is in the European tradition in its disregard for all quantified assessments and its frank emphasis on "eye training" and a "good general sense of visual characteristics." This approach has the merit of unequivocally assigning to intuition a primary rôle in the examination and interpretation of the handwriting record. Its omission of practically all quantified treatment, even that generally recognized and agreed upon as a working standard by reputable European graphologists, suggests a reaction to insistent statistical demands that would toss out the baby with the bath.

Sonnemann's system itself appears to incorporate Saudek's contra-indication method and Klages' concepts of rhythm and contraction and release with their more usual modifications. The author proceeds on several primary and secondary assumptions, the most important of which are (1) that a central unifying system affects characteristically

—that is, individually—all that we perceive and do; and (2) that the writer, in the writing act, in which writing and paper are inherently interrelated, characteristically experiences as an inner reality the attributes ascribed by common symbolism to various spatial positions. Thus, long extensions or upper-lengths of letters, refer to the spiritual, the heavenly, the intellectual, and so on, and the lower projections, or under-lengths, to earthiness, materialism, and so on. This inner experience presumably gets recorded in the writing and can accordingly be analyzed.

This concept of a fundamental inner experience of actual spatial and temporal involvement with the world during the writing act is interesting and provocative, but the author's choice of words to elaborate this thesis and demonstrate its practical application is unfortunate. It professes a direct parallel between the so-called appearance of the handwriting and specific behavior and reaction that under any circumstance would be extremely difficult to demonstrate. For example: "Some of its [the arcade form of connection, which resembles an arch] implications may not at once be obvious; one is a certain feeling of an inner void or vacuum, and of the need to elude that vacuum by the concave perimetric movement of the semi-circle"; and again: "The quantitative extension of the movements . . . never gets involved in 'crippling,' overscrupulous detail, yet while paying full respect to the form potential of each letter, the way it does this is marked by a painstaking affectionateness which seems to cherish the intimate and the idyllic and which we find most of all in those letters—like a's and o's—the very make-up of which invites such movements of a tender caressing."

This type of analysis, which makes the appearance of the writing analogous to human feelings and actions, is likely to lead to misunderstanding and confusion, especially for the layman. For "tender caressing" may or may not refer to actual physical behavior, and tells us nothing of the circumstance and object of this caressing. In this regard, the book as a whole, with its unexplained technical, involved, and redundant phraseology, represents an exercise in reading apart from the subject matter *per se*. To illustrate:

> "Size, therefore, is graphologically taken as a measure of the person's spontaneous self-estimate, of his feeling of self-importance—regardless, again, at this level of the investigation, of any supplementary and qualifying criteria which would inform us about the particular function of the personality around which it is centered, or about the conscious attitude ensuing on it, or about its basis of justification in terms of values and accomplishments; however, it ought to be realized that, as the elevation of any position over its environments determines how much of them is 'overlooked' from there (both in the sense of 'survey,' positively and

> generally, and of 'failure to notice,' negatively and specifically), the level of self-experience is decisive also for the person's external experiences at least in regard to the basic set of aspirations; it determines how widely or closely his focus on reality ranges, what 'size' of objects and objectives, of tasks and challenges, he perceives and how sizeable his scope of attack on reality, if not the force of the attack, is likely to be."

In this reviewer's opinion, the content of handwriting analysis is in itself sufficiently intricate and complex to make almost mandatory a clear, lucid, and concise exposition in any treatment of the subject.

Likewise, the treatment of his material suggests that Sonnemann has fallen into the error of thinking that he must interpret every graphic phenomenon in order to interpret at all. Such a formidable aim inevitably leads to overloading and speculation substituted for accuracy, since this field of study and practice by no means possesses a foundation of stable and consistent graphological agreement regarding the interpretation of all graphic elements. This is not to deny all consistency of agreement, for practiced graphologists, irrespective of differences in analytical methods, are known to interpret similarly certain graphic elements.

In make-up, the book is generously supplied with illustrations and specimens, although Sonnemann's analyses of the latter would have been more helpful and instructive had he indicated, if only generally, the criteria on which his statements are based.

Professionals will probably want to read this book to keep abreast of what is developing in their field. Laymen are likely to find it rough going, with innumerable pertinent questions left unanswered.

ROSE WOLFSON.

New York City.

CLINICAL ELECTROENCEPHALOGRAPHY. By Robert Cohn. New York: McGraw-Hill Book Company, 1949. 639 p.

Clinical electroencephalography has passed the period of early development and now serves as a well-defined tool for the neurologist and the neurosurgeon and, to a lesser extent, for the psychiatrist and the psychologist. Like many specialized tools, however, it can be dangerous in unskilled hands. The competent electroencephalographer and electroencephalographic technician are highly skilled workers, with an intimate and detailed knowledge of their field. Such knowledge does not come easily or in a short time. This means that the majority of physicians who use the electroencephalogram as a diagnostic aid must depend on the electroencephalographer for accurate reports. Yet the interest of these physicians in the subject is great. To date,

there has been no book that could satisfy this interest, which, however keen, is of necessity peripheral.

Dr. Cohn's book is admirably conceived and executed to supply this unfilled demand for information. The format of the book is superb, with clear printing and abundant illustrative material in the form of sample electroencephalographic tracings and graphic presentation of statistical material. The data are clearly presented and well organized. The first chapter discusses fundamentals—physical and physiological aspects of the phenomenon of "brain waves," technique, apparatus, and classification of electroencephalographic findings. In 15 subsequent chapters, Dr. Cohn presents electroencephalographic data in various clinical conditions in turn, including so-called "normal" conditions, tumors, vascular lesions, head injury, and epilepsy. Each chapter consists of a brief summary of the electroencephalographic findings in the clinical condition under discussion. A figure in each section illustrates the findings graphically and allows comparison with a normal group. The body of each chapter, and of the book, consists of sample tracings that illustrate typical and atypical tracings. The value of these tracings is enchanced by the accompanying description and by a summary of the patient's clinical history and findings.

Dr. Cohn's book will not prove so profitable to those workers whose interest in electroencephalography is central. They, however, form a minority of physicians and technicians. The majority, whose interest in electroencephalography is non-technical and peripheral, will find here the only existing book-form presentation of the subject suitable for them. Superb format, clear and concise exposition, and abundant illustrative material combine to make this book eminently suited to satisfy their curiosity about clinical electroencephalography.

MARGARET LENNOX.

Grace-New Haven Community Hospital,
New Haven, Connecticut.

OCCUPATIONAL THERAPY—PRINCIPLES AND PRACTICE. Edited by William Rush Dunton, Jr., M.D., and Sidney Licht, M.D. Springfield, Ill.: Charles C. Thomas, 1950. 335 p.

This book is the coöperative effort of two occupational therapists, a chief of corrective physical rehabilitation, and eight physicians who have had much experience with the prescription and use of occupational therapy. It is really ten small books dealing with as many separate phases of the use of occupational therapy as an adjunct to treatment in at least six medical fields. Three brief introductory chapters present, respectively, the history, principles, and the pre-

scription of occupational therapy, treating these subjects in their general application to the several medical fields. More specific chapters follow.

The foreword notes that until now the few books published have been directed to the occupational therapist and that there seems to be a need for a book on occupational therapy by and for physicians. But while the book was written for physicians, one still feels that in certain chapters the focus has unwittingly shifted to the practicing occupational therapist. Both the physician and the therapist, therefore, will find the book very helpful.

In the foreword and the brief history, some of the high lights in the field are listed chronologically, beginning with the first book on the subject, written by Miss Susan Tracy in 1910. While meantime, according to the foreword, "other writers had been busy," it appears that since "a small manual for physicians" published by Dunton in 1928 (2nd edition 1945), nothing has been printed on occupational therapy except two books "by our English cousins," the first in 1938 and the second in 1941, with a second edition in 1944. This statement must be one of those unfortunate oversights that get by the best of editors, as several books on occupational therapy have been written and published in this country since 1941.

The physician will find here the why, how, and what of effectively prescribed and administered occupational-therapy treatment. The importance of "the attitude of the physician, therapist, and patient" toward prescribed activity, "motivation through rapport between the professional team and the patient," and the achievable objectives of treatment, are all clearly presented for evaluation in the general chapter on principles. The chapter on prescription gives much general advice, as well as suggestions for the use of grafts in functional restoration, choice of occupation, principles guiding the selection of activities, adaptability, and fatigue.

The chapter, *Occupational Therapy For Psychiatric Disorders,* presents the varied goals of therapy as adapted to the several classifications of mental illness.

A chapter on kinetic occupational therapy indicates how the experienced physical-medicine specialist prescribes exercise, "supplying the necessary steps in the formulating of the methods" desired. Cycle of motion, type of muscle contraction, dosage, muscle strengthening, joint mobilization are considered, and auxiliary apparatus, activity during immobilization, and modification of tools and activities are illustrated.

The chapter, *Occupational Therapy for the Amputee,* presents clearly the part played by occupational therapy and the therapist in aiding the amputee to make a wholesome readjustment to life. Here

the psychological insight of the therapist is all-important. The normal fear of being different and being laughed at is all too painfully real to the amputee. Tactfully leading a limbless man to find that he can do many things—even some things that he considered impossible before he acquired his handicap—gives assurance, dispels fear of the future, and inspires the "I-can-and-I-will" attitude. This chapter, prepared by a therapist, stresses the mental as well as the physical re-education of the amputee, shows the part that occupational-therapy activities can play in his treatment, and discusses the modification of equipment and tools and some of the special apparatus designed and used in dealing with patients of this type.

A chapter on occupational capacity and therapy in heart disease notes that in the hands of the physician who is treating those suffering from this disease, occupational therapy can be very valuable. The various etiological types of the disease are considered and the application of occupational therapy in each of them is discussed.

The chapter, *Occupational Therapy in Tuberculosis* takes up diversional, educational, and other closely allied activities, in presenting briefly "the changes in applied therapeutic principles in tuberculosis since 1840." The importance of bed rest is now widely accepted, even though the interpretations of it may differ. A plan that the authors have found most useful is given in detail. The "exercise classification," starting with "complete bed rest," is graded by ten steps or classes until the schedule, at the physician's discretion, may include: "Rest regimen continued. One hour ground privileges. Occupational therapy work in shop: 3 hours."

Occupational Therapy in the Treatment of Cerebral Palsy is a chapter written by an occupational therapist in collaboration with a physician and is, therefore, of special interest both to the therapist and to the physician.

Education for Hospitalized Patients presents very briefly the development and fluctuating use of education in, first, the hospitals of Europe and later in this country, during the past century. Its decline and disuse came as the result of economic stress and reduced hospital budgets. World War II reëmphasized the therapeutic, diversional, and vocational value of carefully selected subjects. The chapter considers purpose, method, subjects, instructors, volunteers, and contraindications.

Bibliotherapy in Neuropsychiatry is a careful study of "the use of books and other reading material in the treatment of patients." Benjamine Rush was not alone in considering bibliotherapy of importance. Records exist of the efforts made by those who followed him, or who were his near contemporaries, to establish libraries for patients. The

chapter is rich in the experiences of those who more recently have recorded the purposeful use of bibliotherapy.

Recreational Therapy has the broadest possible basic concept. It is a feeling, doing, recreating process that is both therapy and fun. Activities may be externalized under the direction of the psychiatrist, so as to produce desirable mental readjustments. In this chapter the following among other things are given consideration: the psychodynamics of play, levels of awareness, situational reactions, classification of activity, and the recreational director's observational report.

The final chapter, *Drama Therapy*, begins by tracing briefly the early development and use of dramatic form as "an acceptable medium in which to express deeper feelings without the anxieties and fears attendant upon such expression." Johann Christian Reil, in his *Rhapsodieen* written in 1803, recommended the use of drama as a form of psychotherapy. The chapter gives summaries of various interesting reports and discusses the varied therapeutic use of drama under such heading as *The Use of Selected Plays Acted by Patients for Therapeutic Purposes; The Use of Original Plays for Psychotherapeutic Purposes; The Psychodrama of Moreno Used Psychotherapeutically; Use of Puppets for Psychotherapeutic Purposes;* and *Analytically Oriented Group Psychotherapy Utilizing Technique of Dramatization of the Psychodynamics.*

Louis J. Haas.

White Plains, New York.

Annual Review of Psychology, Vol. I. Edited by Calvin P. Stone and Donald W. Taylor. Stanford, California: Annual Reviews, Inc., 1950. 330 p.

This publication, under the editorship of Calvin P. Stone and Donald W. Taylor, assisted by an editorial committee of five eminent psychologists, will fill a special need which, during the past several years, has been becoming more and more apparent.

Eighteen topics or sections are included and these are labeled with some rubrics currently used to designate the often vaguely defined fields of psychology. Incidently it is to be noted that the list of topics for Vol. II, to appear in 1951, includes a section on child psychology and one on gerontology. This suggests a healthy flexibility and progressiveness in editorial policy. Another change which, if it could be effected, would be applauded by many psychologists would be the use of the method of reference citations now well established in the majority of psychological journals.

The volume opens with a review of material on growth development

and decline by Harold E. Jones and Nancy Bayley. On theoretical grounds, one might advance arguments for treating in one section both development and decline. Practically, however, in their review the authors do not even attempt to integrate these two concepts. The writers comment on the failure of psychologists to make systematic use of the longitudinal approach in development psychology. This section is little more than a brief abstract of the literature and lacks organization.

Learning theories and a rather comprehensive treatment of recent pertinent studies are contributed by Arthur W. Melton. This section is well organized, and in spite of the author's modest statement, is reasonably extensive in its coverage. There is an active bibliography of 101 items. Melton's evaluative formulations provide a good frame of reference from which to consider the material presented elsewhere in the book.

Vision and hearing are covered by Neil R. Bartlett and Edwin B. Newman. Although discussions of these two topics are necessarily somewhat technical and involve some apparatus unfamiliar to the uninitiated, both Bartlett and Newman point up their materials and evaluate them in such a way that they will be interesting and useful to psychologists whose activities are primarily restricted to other fields. These authors are good teachers.

In the field of somesthesis and the chemical senses, Frank A. Geldard provides us with an erudite coverage.

Robert L. Thorndike, in his paper on individual differences, emphasizes intellectual and cognitive function with especial reference to the organization of attributes. In restricting himself to a relatively limited sphere of special interests, the author gives us a vitally stimulating chapter.

Current personality studies are considered by Robert R. Sears, with an orientation anchored in the tenets of learning theory. For those who are not threatened by this approach, and who do not have special antipathies for verifiers of deductive formulations, Sears' comments will prove to be very interesting and instructive.

Major trends in social psychology and group processes are listed by Jerome S. Bruner as: (1) the translation of traditional social-psychological terms into basic concepts; (2) the consolidation of social psychology and the psychology of personality; (3) focus on the group as a unit of analysis; (4) ferment in opinion-attitude methodology; (5) continued expansion of applied research; and (6) the search for values.

The writer notes that there are few areas in the field in which growth has been orderly. The critical shortage in social psychology

is shown to be the paucity of integrative theory. Notwithstanding the unevenness in integrative theoretical foundations, the processes of social psychology are vigorously alive. Formal theoretical structuring will take shape in the normal maturing of this field of human endeavor. Bruner's manner of presentation is stimulating.

Industrial psychology, which in its practical setting seems to maintain an almost cultishly objective frame of reference, is ably reviewed by Carroll L. Shartle. Of very special interest is the discussion of the extensive experimentation of Hovland and associates on mass communication. This work is of such moment that its applications are immediately apparent in other than the industrial sphere.

Progress in animal and physiological psychology is critically evaluated by D. O. Hebb, of the Department of Psychology, McGill University. At the close of his excellent review, we are startled by his comment that it has long been known that psychotherapeutic methods have little efficacy in psychosis. The evaluation of psychotherapy does not, it would seem, properly belong in this section of the book.

The active bibliography for the section on abnormalities of behavior, by Normal Cameron, includes 142 items. Dr. Cameron has a knack for culling from this extensive literature the significant material and of relating it to fruitful theoretical formulations.

Activity in the field of clinical psychology is attested by the fact that four sections of the book are devoted to the work of those who are oriented specifically toward helping people with personal adjustment problems.

Howard F. Hunt contributes a section headed, *Clinical Methods: Psychodiagnostics.* Tests are shown to provide for more than extended observation. In a more formal sense, they are being exploited effectively for diagnostic implications.

In his chapter, *Clinical Methods: Psychotherapy,* William V. Snyder considers as probably most important those contributions which have been attempting to develop new theoretical explanations of the process of psychotherapy. Concerted efforts to fit psychotherapy into the general framework of psychological knowledge are being shown. Concepts of psychotherapy are being tested by research and experimental methods. The question of who is qualified to practice psychotherapy is a matter of serious concern.

Counseling Methods: Diagnostics is the heading of another section on clinical psychology. In his treatment of this field, Ralph F. Berdie formulates nicely the basic question: to diagnose or not to diagnose. Data are cited on the validity of certain diagnostic tools. These data are of course of special interest for those who believe that diagnosis is an essential initial step in therapy. They are also of theoretical inter-

est for those who espouse a "phenomonological psychology of individual behavior."

In the section, *Counseling Methods: Therapy*, Edward S. Bordin quotes Pepinsky's definition of counseling and then gives Berdie's opposite viewpoint. Throughout his paper Bordin's unbiased critical comments will prove to be a real pleasure for the intelligent reader.

The current revitalization of educational psychology is discussed by Lee J. Cronbach. Studies in this field are no longer confined to relatively sterile studies of drill and individual differences. While the individual as a whole is being stressed, there is sophistication with reference to the untoward effects of overindulgence. Educational psychology is apparently beginning to acquire the professional status that it had in some measure unfortunately lost.

David A. Grant gives a presentation of the mathematical bases for experimental psychological studies in a chapter entitled, *Statistical Theory and Research Design.*

Fittingly, the volume ends with an excellent summary of findings relating to the so-called higher mental functions of problem-solving and symbolic processes.

The *Annual Review of Psychology* is, as we have indicated, much more than a convenient abstracting service. Critical evaluative treatment of the material covered is given by experts in the several fields. It is this aspect of the publication that constitutes its special merit.

EDWARD S. KIP.

Connecticut State Department of Health,
Bureau of Mental Hygiene,
Hartford, Connecticut.

NOTES AND COMMENTS

The Red Feather and Mental Health

In no field is the wise use of our limited funds more essential than in that of mental health. There is so much to be done and so little to do it with that the pilot approach to the solution of mental-health problems is the perennial order of the day. A large part of mental-health work is carried on under governmental authority. Still, the pilot approach has not been so easy for official governmental agencies to carry out. Too often the tendency of government has been to generalize a solution to a problem without first of all putting it through critical tests. At the same time testing has been difficult because to some it seems like discriminatory action in favor of a few, and to others it seems like treating the public as a guinea pig.

It is at this point, therefore, that the voluntary support of pilot experiments is needed. Much of our child-guidance work now widely paid for from public funds was launched through voluntary support. The mental-hygiene activities of non-psychiatric agencies—family and children's agencies, visiting-nurse organizations, hospitals, and so on—are still finding their way under such support.

It has been to a great extent the Red Feather funds that have made this path-finding possible, and it looks as if that would continue to be the case, for under our Community Chests new ways have been opened up and new solutions found that were later generalized. It is the democratic way, for it allows the citizen on his own initiative to act wisely in his rôle as the government, and to find solutions to problems that he can then have supported by legislation. Those who are interested in voluntary psychiatric services or services peripheral to psychiatry have, therefore, a large interest in seeing this system of voluntary effort preserved and strengthened and to this end give fullest support to the Red Feather Campaigns.

First Annual Meeting of The National Association for Mental Health

The First Annual Meeting of The National Association for Mental Health is to be held in Chicago at the Stevens Hotel, November 29–December 1. Because of the tremendous importance of knitting together the national, state, and local organizations into a strong working relationship, the conference will be concerned primarily with matters of organization structure and program planning. Those most encouraged to attend will be the board and general members of the National Association and the board, committee, and executive

representatives of all the state and local groups from across the country.

The conference will be divided into three parts: (1) the annual members' meeting, at which time the directors of the organization will be elected and other business transacted, and the annual meeting of the board of directors; (2) the program sessions, which will be informal in nature and concerned primarily with practical examples on how to proceed to organize, build support, and conduct a program; and (3) a public dinner to be addressed by an outstanding citizen of national reputation through whose message the rôle of The National Association for Mental Health can best receive public attention.

Award of $1,000 Offered for Best Report of Research on Adolescents

The National Association for Mental Health has announced an award of $1,000 for the best report on clinical research that will advance our knowledge and understanding of adolescents and of the ways in which we can help them in their social and emotional adjustment. In offering this award, the association is endeavoring to carry out the wishes of the late Dr. Harry H. Moore, a long-time friend of the mental-hygiene movement, with a special interest in the social adjustment of adolescent boys. The prize-winning report will be published and distributed through all the appropriate channels.

Eligibility.—Any person or group engaged in psychiatric clinical study of the emotional problems of adolescence is eligible to enter the contest. This includes interdisciplinary studies involving participation by social scientists as well as psychiatric clinic-team research. The study must have been undertaken prior to publication of this announcement.

Time Schedule.—The closing date for the submission of entries is June 30, 1952. The prize will be awarded in February, 1953. The entry may be the final report of a completed study or a draft of such a report; or it may be a progress report in a long-range study, so long as it represents the completion of a distinct phase of the total project.

If the study described in the report was completed prior to the announcement of this award, but not published, it would be eligible for consideration, if the study had been completed no more than two years prior to this announcement.

Award Committee.—All entries will be reviewed by the award committee, and their judgment will be considered final. It is understood that the award may not be granted if none of the entries proves satisfactory. In that event, the award will be deferred to a later date and new entries will be invited. Dr. George E. Gardner

is chairman of the committee. The other members are Dr. Abraham Z. Barhash, Dr. Othilda Krug, Dr. Frederick C. Redlich, and Dr. Exie E. Welsch.

Entries should be mailed to Dr. George S. Stevenson, Medical Director, The National Association for Mental Health, 1790 Broadway, New York 19, N. Y. no later than *June 30, 1952.*

Fourth International Congress on Mental Health

The Fourth International Congress on Mental Health will be held in Mexico City, December 11–19, 1951, under the joint sponsorship of the World Federation for Mental Health, Liga Mexicana de Salud Mental, and the Regional Office for the Americas of the World Health Organization. Dr. Alfonso Millan, President-elect of the World Federation, is chairman of the Mexican Organizing Committee for the Congress.

The four major topics to be discussed at the plenary sessions are "Mental Health and Children"; "Occupational Mental Health—Rural and Industrial"; "Mental Health Problems of Transplantation and Migration"; and "Community Efforts in Mental Hygiene."

There will be a series of technical meetings with speakers and discussants from the various countries and professions represented at the congress. In addition to these there will be from fifteen to twenty-five international, interdisciplinary working groups, each composed of approximately fifteen professional people, who will meet daily to exchange ideas, to consider approaches found useful in various countries, and to make suggestions for future planning.

The registration fee for members is $12.00 U. S. currency. A fee of $6.00 for associate members (wives or others accompanying members) will entitle them to attend plenary sessions and any social events that may be arranged. Fees may be sent as a U. S. postal-money order or a draft on a Mexican bank, although personal checks will be accepted from United States members. Checks should be made payable to the Fourth International Congress for Mental Health and sent to Dr. Alfonso Millan, Chairman, Organizing Committee, Gomez Farias 56, Mexico D. F., Mexico.

Sixth International Conference of Social Work

Plans are under way for low-cost group transportation to India for the Sixth International Conference of Social Work in December, 1952. This will take the form of a one-month tour under the sponsorship of the United States Committee of the International Conference, the arrangements being handled by A. S. S. I. S. T. (Affiliation of Schools and Seminars for International Study and Training).

At the present time it is anticipated that the all-inclusive cost for thirty days from New York City and return will be $1,295. In addition to attendance at the conference, there will be occasions for discussion with welfare leaders and inspection of social-welfare institutions in India, Pakistan, and other countries of the East. Travel will be by plane, and there will be opportunities for sight-seeing. If there should be sufficient demand for a longer trip or for a different itinerary from the one proposed, other tours will be arranged.

According to present plans, the conference will take place in Madras. It is expected to be a significant milestone in international social welfare, since it is the first International Social Work Conference held in the Far East. Plans for the program are now being worked out and will be announced shortly. There will also be an announcement in the near future concerning pre-conference study projects in the United States.

All those who are interested in attending the 1952 conference are asked to write the conference office, 22 West Gay St., Columbus 15, Ohio, as promptly as possible. Only in this way can detailed travel plans be worked out.

Mental-Health Week, 1952

The 1952 observance of National Mental-Health Week will take place during the period May 4–10. Since the annual meeting of the American Psychiatric Association is scheduled for May 12–16, the period chosen for Mental-Health Week will be free of any major conflict in so far as dates are concerned.

The theme for next year's observance has not been selected as yet. It can be stated at this time, however, that the 1952 campaign will touch off the most ambitious fund-raising and educational campaign in the history of the mental-health movement.

Group Psychotherapy in Private Practice

The Commission on Group Psychotherapy in Private Practice of the American Group Psychotherapy Association is making a survey of the extent to which group psychotherapy is used in private-practice settings. Very interesting material has already been collected about the various forms of group psychotherapy used. It has been planned to devote one session of the 1952 annual meeting of the association to the private practice of group psychotherapy. All those who are using the method in private practice are invited to participate in this study. Those interested may obtain a questionnaire from Dr. Wilfred C. Hulse, 110 West 96 Street, New York 25, N. Y.

Duke University Receives Grant for Program in Psychiatric Nursing

Duke University has received a grant of $31,202 for a program in advanced psychiatric nursing during 1951–52. Authorized by the U. S. Public Health Service under provisions of the National Mental Health Act, the grant covers the period from July, 1951, to June, 1952.

The program prepares graduate nurses for work at the head-nurse level in psychiatric units of hospitals, child-guidance clinics, and other health centers. One group of nurses has already completed the one-year course, and a second class will be enrolled in September, according to Miss Louise Moser, director of the program at Duke. The program, Miss Moser said, stresses the development of "a more complete understanding and more effective nursing care of people with mental and emotional disorders."

The second of its kind in the South, the program is administered by the Duke Division of Nursing Education. Training facilities available to nurses in the program include those of Duke Hospital, North Carolina State Hospital in Raleigh, Highland Hospital in Asheville, and various community agencies.

The Duke program is conducted in connection with a Public Health Service campaign to encourage more young people to enter mental-health work as a profession.

A Continuation Course in Child Psychiatry

The University of Minnesota will present a continuation course in child psychiatry for general physicians and pediatricians November 26 to December 1, 1951. Dr. Reginald S. Lourie, Director of the Department of Psychiatry, Children's Hospital, Washington, D. C., and Dr. J. Franklin Robinson, Director of the Children's Service Center of Wyoming Valley, Wilkes-Barre, Pennsylvania, will be the visiting faculty members for the course. Dr. Reynold A. Jensen, Associate Professor, Departments of Psychiatry and Pediatrics, University of Minnesota, is chairman for the course.

The Virginia P. Robinson Award for 1951–1952

The Virginia P. Robinson Award Committee of the Alumni Association of the University of Pennsylvania School of Social Work is now ready to proceed with plans for this year's award, which will be made in June, 1952. The award—$500.00—will be made for the manuscript of not less than 6,000 words which best represents an original contribution in the fields of case-work, supervision, or social-work education. Published or unpublished material written

within the past two years may be submitted to the committee by individuals, agencies, or schools, prior to December 31, 1951. Textbooks are excluded. Authors retain publishing rights.

Persons who desire further information regarding the award should communicate with the chairman of the V.P.R. Committee, Miss Mazie F. Rappaport, c/o Department of Public Welfare, 327 St. Paul Place, Baltimore 2, Maryland.

Helping the Patient to Get Well

Helping the patient to fulfill four basic wishes—for adventure, for security, for friendly responses from others, and for recognition of his achievements—is part of the getting-well process. This statement was made by Dr. Edwin S. Burdell, President of Cooper Union, New York, in an address to the graduating nurses of Overlook Hospital, Summit, New Jersey, at the Summit Y. W. C. A. September 7.

"Regaining use of an injured leg, or perhaps learning to walk again, is exciting; and getting back to family, job, or school can be a great adventure," Dr. Burdell said. "The convalescent must be helped to appreciate these events as adventures.

"The need for security is also universal. We need assurance that the crises of old age, illness, and housing will be survived. Likewise, the patient must have confidence in his medical treatment, and confidence that his family, fellow workers, or fellow students will accept him with whatever limitations may result from his illness or injury.

"The patient must feel accepted, wanted, and understood, especially in relative isolation from friends and family in a hospital room.

"Finally, the patient must be made to feel that his recovery is attainable, and he must have personal recognition for enduring his perhaps long and painful illness. If given full credit for his battle with sickness, he will be less inclined to blame himself for having been a burden and expense to his family, an attitude that would retard his recovery.

"The patient," Dr. Burdell concluded, "is your client, not a back, an arm, an appendix, or a lung."

"To Bridge the Gap Between Religion and Medicine"

A new journal, devoted to the purpose of bridging "the gap between religion and medicine," is to make its appearance in February, 1952, under the title *Religion and Health*. The new publication, it is announced, will be approximately 60 pages in length and will appear monthly. It will contain articles by prominent physicians, clergymen, psychiatrists, and laymen, and it will be written especially for laymen.

The journal will be under the editorship of Russell L. Dicks, who has worked in the field of religion and health for twenty years. In 1933, he became associated with Richard C. Cabot, M.D., and served four years at the Massachusetts General Hospital, Boston, during which time he and Dr. Cabot wrote, *The Art of Ministering to the Sick.* Since then he has published ten books and taught in nine theological seminaries. He has been associated with Presbyterian Hospital and Wesley Memorial Hospital in Chicago, and at present is a professor at the Duke University Divinity School and chaplain of Duke Hospital, Durham, North Carolina.

The regular subscription rate to *Religion and Health* will be $3.00, but a special introductory offer is being made of $2.50 for one year and $5.00 for two years. Subscriptions should be sent to *Religion and Health,* Box 4802, Duke Station, Durham, North Carolina.

A Guide to Psychiatric Books

A guide to psychiatric books, with a suggested basic-reading list, for psychiatrists and members of allied disciplines in the psychiatric field, has been compiled by Karl A. Menninger, M.D., in collaboration with George Devereux, Ph.D. The guide, Menninger Clinic Monograph Series No. 7, is published by Grune and Stratton, 381 Fourth Avenue, New York 16.

News of Mental-Hygiene Societies

Compiled by

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Connecticut

The high light of the annual meeting of the Connecticut Society for Mental Hygiene was the honoring of chairmen and committee members who have been working in the mental-health campaign in some 124 Connecticut communities. The Connecticut Society feels that its first state-wide mental-health campaign in conjunction with The National Association for Mental Health has been successful in many ways, in spite of its late start and limited staff. It feels that although it did not reach its quota of $100,000, it gained many new friends, its objectives are better known, and there is greater interest than ever before among the citizens of Connecticut in the promotion of a more adequate mental-health program. Statistically this is what has been accomplished: 124 communities were organized for the campaign under the leadership of local chairmen and co-chairmen who enlisted more than 500 committee members to assist

them in obtaining contributions. Many of these local leaders have indicated that they would like to participate actively in the promotion of mental-health programs in their areas. Fourteen hundred new contributors have been obtained and many former contributors have increased their gifts substantially this spring. While the campaign closed officially on June 30, a number of the community chairmen asked to continue their efforts through the summer.

Florida

The Florida Mental Health Society is pleased with its first intensive program relating to needed appropriations for the state hospital and the Florida Farm Colony, though they feel that this is only a first step in the right direction. The Florida State Hospital did get additional funds—$900,000 for Negro wards for men and women; $300,000 for long overdue repairs; a salary raise for the superintendent; and money to reduce the long hours of attendants and other personnel. The Florida Farm Colony can be increased by 110 beds. Provision was made for the beginning of a Negro unit of 150 beds, and the hours of some of the attendants may be reduced from 72 hours a week to 60 hours. The Florida Mental Health Society feels that all this is largely due to the splendid work and activity of Mrs. Richard Stover, chairman of its legislative committee, in arousing interest all over the state in the mental-health program. Resolutions supporting the program were passed by the county judges association, the state association of county commissioners, county attorneys, the Florida Federation of Women's Clubs, Pilots Clubs, the Junior Chamber of Commerce, the Florida Medical Association, the Women's Auxiliary of the Florida Medical Society, the Florida Department of the American Legion, the Florida Department of the American Legion Auxiliary, the Business and Professional Women's Club, and the Florida Psychiatric Association, plus many local civic organizations, women's clubs, men's clubs, fraternal-church groups, and so on.

Other legislation of particular interest was the Child Molester Act, which makes psychiatric examination and commitment for sex offenders permissive; the opening of Forest Hills School for delinquent Negro girls; the act which makes it permissive for counties to establish juvenile courts; the act to provide for temporary commitment to the psychiatric ward of a general hospital or a psychiatric hospital for not more than 90 days without taking away civil rights; and a hospital for alcoholics.

The chairman of the legislative committee of the society called a meeting in September of state cabinet officers, institutional heads, and others who might participate in the planning of the society's future social-action program.

The Mental Health Society of Southeastern Florida is participating in the "Flying Seminars," a project to obtain lecture engagements for eminent speakers on their way to the International Congress on Mental Health, to be held in Mexico City in December. The University of Miami is to be a joint sponsor. The society also participated in a clergy-training conference for the Episcopal Diocese of South Florida. The play, *Scattered Showers,* was given by the Church of the Redeemer, Avon Park, and was such a success that several churches have used it since then. The society distributed program-suggestion lists, pamphlet lists, and copies of *Mental Health Is 1–2–3.* The executive director of the society gave a short talk on mental-health-education material as a program suggestion.

Miss Parks, executive director of the society, showed the film, *City of the Sick,* and spoke at a meeting of the Florida Council of Churches to arouse their interest in the needs of the institutions. This society also showed the film, *Preface to a Life,* at a teen-age camp, where the response was excellent.

Illinois

The Illinois Society for Mental Hygiene informs us that the appointment of Dr. Agnes Sharp, a member of the society's board of directors, as supervisor of volunteer services for state mental hospitals, has been announced by Hermon Dunlap Smith, chairman of the board of public-welfare commissioners. Supported largely by Field Foundation funds, the training program for volunteers will be initiated via a pilot project at Kankakee State Hospital and volunteers will be recruited through organized groups in the community. The society also informs us that board members of agencies are invited to participate in the planning of a course designed especially for board members and staff executives, offered by the Welfare Council of Metropolitan Chicago in coöperation with the University of Chicago.

Three new health services for children have been initiated by the department of public welfare: (1) a hospital specializing in psychiatric treatment for children under eighteen, to be located in Chicago's Medical Center District; (2) a diagnostic and treatment ward for emotionally disturbed children at Illinois Neuropsychiatric Institute; and (3) a unit for the treatment of youthful mental patients at Galesburg Research Hospital. Impetus for the provision of special facilities for children was originally given by the Children's Commission, sponsored by the society in 1948–49.

Every Thursday, beginning in July, Station WFJL, in coöperation with the society, has presented 15-minute transcribed programs to demonstrate practical mental-health principles.

In the July issue of the society's newsletter, we note that three

bills that had been endorsed by the society for several years were voted by the assembly to go into operation as of July 1, 1951. Their passage provides the following improvements in Illinois mental-health legislation: (1) codifies all laws relating to mental patients in a single act; (2) authorizes the state to charge patients or their near relatives for care; (3) enables agreements with other states for the exchange of non-resident patients; and (4) eases procedure for the commitment of patients by courts. The section of these bills most discussed was the proposed payment plan. Similar plans are already operating successfully in 45 of the 48 states and have made substantial contributions to the quality of services provided for the mentally ill.

Some 45 students, under the sponsorship of the American Friends Service Committee, participated in an orientation program in preparation for their summer placements as state-hospital aides. The Peoria State Hospital and the society participated in the orientation group workshops which studied motivations for engaging in a mental-hospital program. The mental-health film, *Angry Boy*, was shown and discussed. Students reported to their assignments at Dixon, East Moline, and Peoria.

The society informs us that both Manteno and Elgin state hospitals have been conducting clinical-pastoral-training programs for clergymen. Seven theological students from all parts of the United States are currently enrolled at both hospitals, which coöperate with the Council of Clinical Training, Inc., New York. In Chicago, Augustana (Lutheran) Hospital is embarking, for the third year, on its summer seminar for clerical orientation. Sixteen clergymen of various denominations are registered for this program, which is affiliated with the Institute of Pastoral Care, Cambridge, Mass. Representing the society in mental-health sessions were Harry Rowe, M.D., of the Veterans Administration, and Maryan H. Brugger, the society's education director.

Since last November, the society has been working with the World Federation for Mental Health, through The National Association for Mental Health, on the project to bring to Illinois well-known psychiatrists and social scientists from many parts of the world, *en route* to the International Congress on Mental Health in Mexico City. Local agencies and organizations participating in these "Flying Seminars" include the Veterans Administration, Michael Reese Hospital, the Illinois Department of Public Welfare, the Institute for Psychoanalysis, the Institute for Juvenile Research, the Chicago Medical School, and the Psychology Department of the University of Chicago.

Maryland

The Mental Hygiene Society of Maryland informs us that after four years of leadership, during which the mental-hygiene society has developed into an agency with a membership of over 5,000, Edward E. Yaggy, Jr., retired from the presidency at the annual meeting in June. Succeeding him for the 1951–52 season is Mrs. Adolf Hamburger, who for the past two years has been a director of the society and a member of the community-clinics committee.

The membership of the society increased 350 per cent in the past year. The total number of new members recruited in the membership drive was 3,022. Leading volunteers in the drive were guests of honor at the annual meeting.

One of the outcomes of the four workshops for party-giving groups of volunteers arranged by the society was the request by volunteers for a weekly group meeting based on their relations with patients and staff in the mental hospitals.

Mrs. Dorothea Wisman, the society's director of service to the mental hospitals, prepared a book list for volunteers, suggested by the Enoch Pratt Free Library. It includes material on arts and crafts, and recreation, as well as on psychiatry. The society recommended this as summer reading for those who plan to work in mental institutions in the coming season.

The memorial-library committee of the society is considering a demonstration, with professional staff and volunteers, in providing service to the patients of one of the state mental institutions, to determine just how valuable a library can be for the mentally ill.

A planning committee was set up this summer to develop program and structure for a chapter of the state society to serve both Caroline and Talbot counties. The Eastern Shore Chapter of the state society was formally launched in June at a meeting in Easton, and the statement of purposes and by-laws was adopted by the group.

Massachusetts

The June newsletter of the Massachusetts Association for Mental Health has an excellent article, *Guide to Community Planning*, which we feel might be of interest to other mental-health associations in forming their programs. In this newsletter, we also noted the mention of a mental-health booth at the Hundredth Anniversary Meeting of the Franklin District Medical Society. Margaret C. McManamy, M.D., of Orange, Mass., had gathered together from state and voluntary agencies much interesting material: from Belchertown State Hospital, pictures of various occupations taught to its patients; and from Monson State Hospital, articles made under the supervision of the occupational-therapy department. Also shown were many tracings of brain waves helpful in diagnosing epilepsy and other organic

disturbances of the brain. Miss Bunyan, who, because of her work at Monson, received the national award as psychiatric aide for 1950, and Miss Vennert, Superintendent of Nurses at Monson, showed films of the children's activities at the hospital and other films relating to mental health.

Dr. McManamy, Miss Reilly, social worker from Northampton State Hospital, Mrs. Alice Collins, psychiatric social worker at the Child Guidance Clinic of Springfield, and Mrs. Parker, consultant from the Massachusetts Association, were present to answer questions and to discuss a wide selection of literature on mental health.

The society's second Mental Hygiene Institute for Educators was planned for later September or early October. The following subjects for discussion have been proposed; emotional reactions to children, to adolescents, and to colleagues, and administrative interpersonal relations. Further details on this institute will be given later.

New Jersey

The New Jersey Association for Mental Health has held several board meetings focused for the most part on the contemplated program of the association. During this year it hopes to intensify its activities, particularly in relation to a field study of the needs and resources for mental health in the state.

We note, in the first fall bulletin of the Atlantic County Association for Mental Health, that its volunteer activities include the staffing with a receptionist of the out-patient clinic of the Trenton State Mental Hospital. The clinic is held in the Atlantic City Hospital twice a month. The musical-entertainment programs at Northfield, which were temporarily halted for the summer months, were resumed during the middle of September. The education committee has plans for an active season and has scheduled its first fall lecture for early October.

The Mental Health Society of Bergen County informs us that its founder and first president, Mrs. Pauline Rappaport, has retired and is being succeeded by Dr. Evelyne Slabey.

At the end of its first year of operation, the society feels that it has stimulated an interest in the positive aspects of mental health by disseminating reliable information about mental hygiene through its speakers bureau, which reached thousands of people in all parts of the county and in all walks of life. Besides its meetings, the society feels that a strong link in its educational program was provided by its pamphlets-and-exhibits committee.

The Union County Association for Mental Health reports that it is continuing its film workshop for community leaders, P.T.A. rep-

resentatives, etc., throughout the county. It is also planning a workshop for discussion leaders, so that they will be prepared to lead discussions after the showing of films, plays, etc. Only fully qualified professionals will be invited to participate. News of the progress of this workshop will be given later in detail.

New York

Mrs. Ralph E. Henderson, President of the Board of Directors, and David Rauch, Director, of the Mental Hygiene Association of Westchester County, have informed us that they feel that the fund-raising campaign, the first local organized fund-raising campaign in conjunction with The National Association for Mental Health, was successful in three ways:: (1) in education, more than 35,000 educational pamphlets having been distributed to people who were thus informed of the work of the association; (2) in organization, more than 300 volunteers having participated in the campaign, thus establishing a firm foundation for future activities in Westchester County; and (3) in finances, more than $18,500 having been raised to date in the county from the campaign.

North Carolina

The July newsletter of the North Carolina Mental Hygiene Society reports that the North Carolina Neuropsychiatric Association is planning to meet with the mental-hygiene society on November 14 in Raleigh in joint sponsorship of a mental-health institute, speakers to be secured, if possible, from the "Flying Seminars." These speakers, as stated above, are *en route* to the international meeting in Mexico City.

At the June board meeting of the society, there was considerable discussion of the function of its various committees, and it was agreed that a definite statement of the function of each committee was needed so that the program of the society could be focused on definite objectives during the coming year.

We note that Miss Elsie Parker is no longer with the North Carolina society, and that Miss Ethel Speas is now its executive secretary.

Ohio

The following information was secured from *Ohio Lights on Mental Health*, the quarterly bulletin of the Ohio Mental Hygiene Association:

Representatives of the mental-hygiene associations of Richland County, Wayne County, Huron County, and Ashland County met with representatives of the state association to help formulate plans for a center to provide volunteer informational services. The Ashland

County Mental Hygiene Association was officially organized early this year and is working in active coöperation with P.T.A.'s and other community groups.

The Education Committee of the Butler County Mental Hygiene Association is sponsoring in-service training in mental hygiene for elementary-school teachers in coöperation with Miami University.

Current activities of the Clark County Society include the preparation of a mental-hygiene booth for the Clark County Fair, the development of a speakers bureau, the publication of a newsletter, and an intensive membership campaign.

In this same newsletter, we note that legislation was listed as the number-one priority on the Cleveland Mental Hygiene Association's agenda. Its annual meeting brought together leaders in the fields of industrial relations, religion, public-health nursing, and child care in four morning workshops on the theme, "Mental Health—Everybody's Job." At the luncheon meeting, Dr. E. O. Harper discussed "Improving Cleveland's Mental Health Services"; and in his talk "unveiled" the Cleveland association's "Survey of Cuyahoga County Residents under Treatment or Awaiting Treatment in October 1950."

Louis B. Seltzer, editor of the *Cleveland Press,* presented awards to six state-hospital attendants from Cleveland's three state hospitals, as outstanding psychiatric aides of 1951.

The Cleveland Association has appointed four new local committees: (1) a committee on family care; (2) a committee on annual psychiatric-aide awards; (3) a committee to study the expansion of outpatient psychiatric facilities; and (4) a committee to study ways of helping to effect maximum coördination with other local and state mental-hygiene organizations.

Meetings of the North Franklin County Association were held alternately at Westerville and Worthington, and this association was official host to the Ohio State Association at its annual meeting in Columbus.

The professional workshops and other interest-group meetings have been found most successful in the educational program of the Miami County Association. This spring such meetings included: a seven-weeks seminar on "Pastoral Counseling"; three weekly sessions of a church-workers institute on "Child Development"; a workshop for school personnel on "Human Relations Classes," with delegates from all the schools of the county; and seven Monday-afternoon mental-health-film previews, presented for community leaders and program chairmen of community organizations.

The most recent publication of the Miami County Association is its *Mental Health Resources—A Directory for Miami County.* This directory lists administrative and informational agencies, as well as

psychiatric resources for the mentally deficient and retarded; for delinquent, dependent, or neglected children; and for handicapped children. The directory was prepared for the use of individuals and agencies working closely with people and their problems. Howard A. Buchanan, of Covington, chairman of the directory committee, and Miss Harriett Neese, psychiatric social worker of the Upper Miami Valley Guidance Center, served as editors.

Mental-hygiene legislation has been given active support. Representatives have attended all important legislative hearings and have urged the enactment of legislation outlined by the Ohio Mental Hygiene Association Legislative Committee.

The Montgomery County Mental Hygiene Association is promoting a "big push" to establish a full-time mental-health clinic for the people of its county. Only six hours per week of such service is now available through the part-time clinic, which is attempting to serve a population of nearly 400,000 people. The association is providing the leadership for the coördination of all efforts in behalf of this project. It is also promoting an over-all educational program to acquaint the public with the need, services, and value of such a clinic. This is necessary in order to get full support both from laymen and from professional groups.

The fourth annual summer training course sponsored coöperatively with the Dayton State Hospital has been successfully completed. Sixteen lectures were given, open to professional workers of all types. In addition, eight weeks of full-time hospital experience were given to eight selected persons from this area.

Several major institutes are being planned for the coming season. One will deal principally with community-clinic-service programs. "Flying Seminar" speakers have been invited to participate in these institutes.

Much of the work of the association has had to do with the activities of the Montgomery County Council for Retarded Children. Guidance has been offered on all kinds of questions that arise in the establishment and development of such a group in a large community. The council plans to open two half-day classes in September for seriously retarded children who have been excluded from school.

The Montgomery County Mental Hygiene Association has also worked coöperatively with the recently organized Council on Alcoholism and had much to do with its development to the point of formal organization.

Two research projects sponsored by the Wayne County Association are being directed by Dr. Stewart Adams, of the department of sociology, Wooster College: (1) a study of county records reflecting

social problems that resulted from mental and emotional maladjustments; and (2) a study of community attitudes toward mental-health programs, and the attitudes of citizens toward accepting services.

This association has adopted a seven-point program for the coming year, one point being the expansion of volunteer services to the state hospital.

Oklahoma

The July newsletter of the Oklahoma Committee for Mental Hygiene states that this organization has a membership of more than 4,000. The newsletter also includes notes from the state hospitals which show their appreciation of the volunteer services provided them. The Oklahoma Committee is responsible for a column of news, discussing important questions of mental hygiene, that goes out weekly to hundreds of state newspapers. It has available outlines for projects for groups interested in working directly with the mental hospitals of the state.

Oregon

The Mental Health Association of Oregon has had a very active year. Meetings have been held with practically all the parent-teacher groups; talks have been given to professional and business clubs; and a thorough study has been made of the state's three mental institutions. The executive participated in a teachers institute at the Eastern Oregon College of Education; the Washington County Teachers Institute; the County Teachers Institute (pre-school) for seven counties at La Grande; and a lecture series at the University of Oregon. The association had a booth at the Multnomah County Fair and the state fair, and prepared material for a coming lecture series of which it is sponsor. The association's executive also made a study of the mental-health aspects of the Klamath Falls Indian Reservation.

South Dakota

The South Dakota Mental Health Association informs us that 11 towns have made partial reports on the membership campaign featured by chain coffee-and-doughnut breakfasts. These reports show a total of 330 members secured and $1,600 collected. The largest towns have just started their campaigns.

The outstanding report to date is from the little town of Alcester, of about 500 population. It has sent in $213, reports $117 more on hand, and promises at least $400 total. A farmer's wife, Mrs. Melvin Leafstedt, and a school superintendent's wife, Mrs. V. W. Madsen, are doing outstanding work there.

The Institutional Service Unit, although small—six students and a pastor and wife as assistant directors—has been very successful. Dr.

Haas, of Yankton, has asked for them again next year, and Fort Meade is also planning on using the group.

Mrs. Watson, secretary of the association, states that she feels that one of their most outstanding accomplishments has been that, through their efforts and their increased numbers, most disturbed women patients could be taken out-of-doors for the first time in ten years.

The association was given space in the Sioux Empire Fair in Sioux Falls and in the state fair at Huron, where it presented displays. These consisted of enlarged pictures of the Pastoral Counseling Institute and of a minister doing pre-marriage counseling; of the Institutional Service Unit group and of two of them feeding patients; of two of the coffee-doughnut membership parties; of a map of the state showing admissions and discharges (Yankton) by counties, and also of mentally retarded who have been tested, by counties, in order to show how much we need to enlarge our hospitals; and a poster showing South Dakota's rank of 9th in the 48 states in per-capita income, but 45th in maintenance cost of hospitalized mentally ill.

The association is holding its fourth annual meeting on October 10, 11, and 12 in conjunction with the South Dakota Conference of Social Work. The first day will be devoted entirely to mental health, and the programs of the next days will include many mental-health topics.

Texas

In the early summer, the central office of the Texas Society for Mental Health assembled at luncheon the field representatives of some twenty state and federal agencies whose services include some phase of mental hygiene, to explain to them the program carried on through the eighteen affiliated mental-health societies. Among the agencies represented were the state department of public welfare, the vocational-rehabilitation and home-and-family-life divisions of the Texas Education Agency, the public-health-nursing and mental-health divisions of the state department of health, the state tuberculosis association, and the schools of education and social work and the extension division of the University of Texas.

It was agreed that regular bi-monthly meetings of the group would be helpful; also that each representative should make a telephone call or personal visit to the president or other officer of the local society in the cities he visited in the course of his duties, and through suggestions and inquiries, see how the local society and the state agencies could be mutually helpful to the community. A brief report to the state society would be given whenever developments in the field warranted it. From this interchange it is hoped that a better

understanding of the mental-health field and its avenues of expression may be brought about.

The Louie Migel Center for Older People, an integral part of the Municipal Recreation Department of Waco, was formally opened on July 18. The first of its kind in Texas, the center was established through the leadership of the local chapter of the American Association of University Women, members of the McLennan County Mental Health Society, and other citizens interested in providing various forms of entertainment and recreation for the older people of Waco. Reports indicate a wide and enthusiastic use of the center in spite of the heat.

That the Tarrant County Mental Health Society has established enviable rapport with the large newspapers of Fort Worth is evidenced by the appearance of four articles relating to mental health in a recent single issue of the *Fort Worth Press:* "Mental Health Is Easy to Recognize" (quotes *Mental Health Is 1–2–3)*; "Make Home Attractive or Hubby Will Get Bored"; "The Mature Parent"; and "Happy Home Lives, Love, Seen as Preventatives of Dope Addiction." The Fort Worth papers also have given convincing and effective support to measures relating to the state hospitals during the last session of the legislature.

The Nineteenth Annual Conference of the Texas Society for Mental Health will be held in Fort Worth, March 6 and 7, 1952, with "Better Mental Health for Texans" as its theme. In addition to four general sessions, there will be discussion groups, with well-qualified leadership, under five sections: religion, industry, education, community activities, and care and prevention of mental illness.

Each summer for the past three years, the Guidance Institute and Bexar County Society for Mental Hygiene has given scholarships to experienced, selected teachers and principals employed in the San Antonio public schools, for special study in the fields of child development and guidance. Columbia University, the University of Texas, and the Worden School of Social Work have been the training centers used by the scholarship program.

This year, the Guidance Institute Scholarship Committee decided to implement its usual summer program by also sponsoring a project that would bring help to a large number of teachers and administrators in its own community. A one-week guidance-workshop idea was developed with and sanctioned by the school officials in the area. The week of August 20–24 was chosen for the workshop because administrators and counselors would be back on duty then, and it would be the week before school personnel became busy with the registration of new students and other pre-opening activities.

San Antonio has five independent school districts, each of which co-sponsored the workshop, lending active committee participation and financial assistance. One district contributed as much as $300.00. The Administrators' Association and the Teachers' Council of San Antonio also made sizable financial contributions, as well as the Community Welfare Council. The Hogg Foundation for Mental Hygiene was another sponsor, coming to the fore with consultative assistance to the program-planning committee.

Three local colleges—Trinity University, Incarnate Word, and Our Lady of the Lake—offered one-hour graduate credit for the workshop, and 71 teachers registered for credit. In all the workshop enrolled a total of 500 teachers, administrators, counselors, visiting teachers, school nurses, and other personnel during the week.

Dr. Frances M. Wilson, Director of Guidance, New York City Schools, and Mr. Donald E. Kitch, Chief, Bureau of Guidance, California State Department of Education, were the workshop's chief consultants, giving inspired leadership throughout the whole week. Local mental-health-resource staff members served as group-discussion leaders. They were psychologists and psychiatric social workers from Brooke Army Hospital, Randolph School of Aviation Medicine, Lackland Airforce Base, and the Brooke Army Child Guidance Clinic.

The workshop was divided into morning and afternoon sessions. All participants met together in the mornings, and broke into small discussion groups for the afternoon, divided on the levels of elementary teachers, elementary principals, secondary teachers, secondary principals, counselors, visiting teachers, and others. There was a general session before the conclusion of each day at which reporters from each of the various discussion groups summarized their section's findings.

At the final general meeting, Dr. Wilson asked all participants to divide into small groups of six, in order to list and report on six things that individuals, the schools, and the community can work on during the next year to improve the guidance program in San Antonio. As the next big step, the Guidance Institute and Bexar County Society for Mental Hygiene will compile these findings and recommendations into a report that will be sent to each school in the San Antonio area. Then a committee of school representatives will be asked to work through the Guidance Institute to select, from the report, areas on which action may be started this year.

West Virginia

The Huntington Mental Health Association met in June. Mr. Harold Martin, technical director at the International Nickel Company, was elected president to succeed Mr. Lindsey Yost. New members were also added to the board of directors.

Wisconsin

The annual meeting of the Wisconsin Society for Mental Health was held in September. The society writes us:

"*Mental Health Is 1–2–3* has proved an excellent illustration of a practical approach in literature that can be carried away in pocket or purse. We distribute it at public meetings and refer to it repeatedly in our addresses. Requests to make it known to a wider audience continue. The Northwestern Mutual Life Insurance Company reprinted it with a credit line, in the July issue of the *Northwestern Mutual Pillar*. The Equitable Assurance Company, Milwaukee office, requested 100 copies of it for their employees in the state. The Milwaukee office of the Blue Cross has requested permission to reprint it in their employee publication. A program 'guide' in preparation for the social-studies section of Wisconsin's American Association of University Women includes it with a credit line.

"The society was invited to participate in a late August Conference of Rural Women. Approximately 150 women, leaders in their respective rural communities, attended.

"*The Happy Kindergartner and How He Got That Way*, by Jessie Hall, a reprint from the August, 1949, issue of *Mental Health*, quarterly publication of the society, has been reprinted twice. School boards and superintendents are purchasing it in quantity lots and distributing it to mothers of kindergartners, present or prospective.

"*As the Twig Is Bent*, by O. N. de Weerdt, appearing in the June issue of *Mental Health*, has found widespread favor because of its contribution to a better understanding of attitudes when individuals feel 'shut out.' Within the state, the Governor's Commission on Human Rights and the Wisconsin Committee on Children and Youth are co-sponsoring a reprint of this article in appropriate form for widespread distribution."

The Milwaukee County Society for Mental Health reports that its committees have been active during the last three months. The education committee's major event of the year was the second Mental Health Education Workshop in June at the Milwaukee State Teachers College. A detailed report on this workshop will be available in the future for $1.00. One hundred and fifty-eight persons enrolled, and over 200 were present at the mid-week evening program, which was open to the public. Tours to mental hospitals and community agencies were well attended. The Milwaukee Public Library furnished an excellent book and pamphlet display as well as mental-health films.

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